State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
December 2011

Risk Adjustment and Reinsurance: A Work Plan for State Officials

Prepared by Wakely Consulting Group – Ross Winkelman, FSA, MAAA; Mary Hegemann, FSA, MAAA; Syed M. Mehmud, ASA, MAAA; Tom Leonard, FSA, MAAA; James Woolman; Julie Peper, FSA, MAAA; Patrick Holland

The State Health Reform Assistance Network is a national program of the Robert Wood Johnson Foundation.

Robert Wood Johnson Foundation

TABLE OF CONTENTS

Risk Adjustment and Reinsurance: A Work Plan for State Officials

Prepared by Wakely Consulting Group – Ross Winkelman, FSA, MAAA; Mary Hegemann, FSA, MAAA; Syed M. Mehmud, ASA, MAAA; Tom Leonard, FSA, MAAA; James Woolman; Julie Peper, FSA, MAAA; Patrick Holland

1. Overview

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) issued proposed rules, titled "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." The proposed rule implements standards for these programs for states and health insurance issuers (e.g. health insurance companies and HMOs). These programs are intended to mitigate the impact of adverse selection and lessen the financial risk health insurance issuers ('issuers') will face under the Affordable Care Act (ACA). Under separate cover titled, "Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors, and Risk Adjustment,"[1] Wakely has already provided a summary of the proposed rules and resulting implications.

As a follow-up to that research brief, Wakely Consulting has developed this work plan, which lists the decisions states need to make and the actions they need to take to implement the risk adjustment and reinsurance provisions of the ACA.[2] The paper includes the rationale for these decisions and actions, while the accompanying timeline describes the associated timing under various scenarios. This paper and the accompanying timeline were developed with the ten State Health Reform Assistance Network (State Network) states in mind, although it applies to other states as well. Each state implementing the provisions of the ACA will hopefully find these materials helpful but will need to make changes to reflect the goals, resources, and other specifics of the state and its health insurance marketplace. In addition, pending federal and state regulation and guidance may materially affect the recommendations or timelines in this paper.

The proposed rules related to reinsurance and risk adjustment allow states additional flexibility in return for increased state responsibility, especially for risk adjustment. For example, states may want to take on the responsibility of administering the risk adjustment program in order to use a risk adjustment model that is different than the federal model. The model selected may be consistent with that used in the Medicaid program or one with which the health insurance marketplace is familiar. Alternatively, or in combination with model selection, the state or health plans may want to use an approach that differs from the federal methodology to address concerns specific to that state's market such as morbidity characteristics of the currently uninsured.

It is important to note that this paper is relevant to both states that elect to allow HHS to define and administer as much of these programs as possible and to states that elect to customize and administer these programs. For states that elect to defer as much as possible to HHS, stakeholder engagement and simulations will be critical and the health insurance exchange and other state agencies will play a key role in making sure these efforts are successful.

Work plans that have been developed under four key scenarios are described below for the analysis and preparation required for 2014 (see Appendices):

- Scenario 1: Detailed data used, state considers alternative risk adjustment method, long time frame (i.e. state has begun work or will soon)
- Scenario 2: Detailed data used, state does not consider alternative method, short time frame (i.e. state has not begun work and will not begin soon)
- Scenario 3: Summarized data used, state does not consider alternative method, short time frame

[1] Wakely Consulting Group, *Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors And Risk Adjustment*, September 2011, www.rwjf.org/coverage/product.jsp?id=72682

[2] The risk corridor program is a federal program which depends on the results of the risk adjustment and reinsurance programs (and not vice versa). Therefore, this work plan focuses on the risk adjustment and reinsurance provisions.

- Scenario 4: Summarized data used, state considers alternative method, long time frame

As discussed throughout this paper, these scenarios are representative of broad situations and approaches. The situation and approach for any given state will vary significantly.

2. Key Decisions

States need to make a number of key decisions with respect to the risk adjustment and reinsurance provisions of the ACA. Decision areas that fundamentally affect the level of effort and timing of these programs are included below, listed roughly in order of importance. A full discussion of each decision, including the detailed technical issues is outside the scope of this work plan. However, these decisions will generally be driven by the specifics of the state's health insurance marketplace both pre and post reform, the level of stakeholder engagement, different stakeholders' perspectives, the state's goals and resources, and the availability of the necessary data.

2.1 PROGRAM RESPONSBILITY

The proposed rules require states to manage their reinsurance program if the state is also operating an exchange. If a state is not operating an exchange, they can still manage the reinsurance program or let HHS administer it. Risk adjustment is similar in that local operation of an exchange allows that state to also utilize a methodology different than the federal prescribed one. However, unlike reinsurance, states may allow HHS to administer the risk adjustment program even if they have a state-based exchange. The table below has been repeated from the Wakely issue brief on the proposed rules[3] for purposes of clarifying the various options available and to reinforce the markets to which each program applies.

ACA Provision	Sold within Exchange		Sold Outside Exchange			Who Administers	
	Individual	Small Group	Individual	Small Group	Grand-Fathered	State Run Exchange	Federal Run Exchange
Risk Adjustment	Yes	Yes	Yes	Yes	No	State or HHS *	HHS
Reinsurance	Yes	No	Yes	No	No	State	State or HHS *
Risk Corridor	Yes	Yes	No	No	No	HHS	HHS

* State can decide to administer or allow HHS to administer. If HHS administers, all parameters will be federal.

There are a number of important issues that go into the decision to manage one or both of these programs. The level of resources required to administer this complex program and the availability of data (i.e. through an All Payer Claims Database [APCD]) are very significant issues, especially for risk adjustment. In addition, the state's (and other stakeholders') desire to control these programs, particularly risk adjustment, may drive the state toward taking on this responsibility. If the state decides to have HHS administer the risk adjustment program, work by the state required in 2014 and beyond decreases considerably. However, the work in 2011, 2012, and 2013 does not change significantly since issuers need information on the impact of risk adjustment and reinsurance to develop pricing for 2014, and HHS will not be able to provide significantly detailed information prior to 2014. The resources necessary to manage reinsurance are lower than those required to manage risk adjustment, but are still significant.

[3] Wakely Consulting Group, *Analysis of HHS Proposed Rules On Reinsurance, Risk Corridors And Risk Adjustment,* September 2011, www.rwjf.org/coverage/product.jsp?id=72682.

2.2 FEDERAL OR STATE RISK ADJUSTMENT MODEL AND KEY TECHNICAL ISSUES

Risk adjustment programs require a risk adjustment model. The proposed rules indicate that HHS will release a federal model in October 2012. States that want to use an alternative model[4] need to submit it to HHS for review in November 2012, with HHS proposing a maximum two-month turnaround for their review (by January 2013). The short time period between the release of the federal model and required submission of state models means that states need to start analyzing alternative models early in 2012 if they are at all considering an alternative model. Other hybrid options include using the federal model, but making fundamental changes to it like recalibrating the risk weights or using the model's output differently than proposed under the federal risk adjustment methodology. These changes would also require federal approval, with the assumption that the approval process would be less difficult.

In addition to the choice of the risk adjustment model (i.e. the software tool), if a state decides to pursue an alternative risk adjustment program, there are other key technical decisions which will need to be made including the following:

a) Prospective vs. Concurrent/Retrospective model
b) Include pharmacy categories or not
c) Data fields to be used (e.g. first five diagnosis fields versus all available)
d) Appropriate premiums to apply risk adjustment results
e) Rating variables and rating variable integration
f) Area calculations and adjustments
g) Scoring for members with insufficient experience

As mentioned above, a detailed discussion of these technical considerations is outside the scope of this paper. Please contact the authors directly and review other available resources for further information on these issues.

2.3 FEDERAL OR STATE REINSURANCE PARAMETERS

States can use the federal reinsurance parameters or develop state-based parameters. While the contribution rate (what all issuers and TPAs will contribute to fund reinsurance) will be set uniformly on a national basis, HHS is expected to publish federal reinsurance parameters based on the market characteristics of each state rather than publishing one set of federal parameters.

The primary issue that will drive each state's reinsurance parameters is the relative size of the projected non-group market in 2014, 2015 and 2016. However, some states may have an expected mix of healthy and sick individuals that is different than the national average or assumed by HHS. In addition to the federal contribution rate, key reinsurance parameters that will be defined around mid-October of 2012 are as follows:

a) Attachment point
b) Maximum coverage level
c) Coinsurance level

It is expected that states wanting to file either contribution rates or parameters different than the federal ones must respond to HHS by November 2012. Final notice of federal factors will be in January 2013, with states altering these needing to provide public notice no later than March 2013 for use in 2014.

2.4 ANALYSIS AND SIMULATION

Issuers will be faced with significant uncertainty with respect to pricing their products in 2014 because of the significant changes under the ACA, including the impact of the risk adjustment and reinsurance programs. When issuers experience uncertainty, they often increase rates or simply choose not to offer products in that market, either of which will protect their organizations from exposure to excessive financial risk – either of which is undesirable from a state and, ultimately, a consumer perspective.[5] No matter how much analysis is completed prior to 2014, significant uncertainty will still exist.

[4] A number of risk adjustment models are currently being used for risk-adjusted payment in Medicare, Medicaid and other public programs including Medicare's HCC, CDPS, MedicaidRx, ACGs, ERGs, and DxCG. Others have been developed specifically for reform programs including Milliman's MARA, Johns Hopkins' ACG reform model, and Wakely's WRA model.

[5] Risk adjustment and reinsurance not only lessen issuer (Health Insurance Company) risk, but they also lessen incentives for issuers to target healthy individuals. This represents a fundamental shift in the marketplace, one that benefits individuals who need insurance the most and who can benefit the most from care coordination and medical management.

However, analysis can be performed which will lessen the uncertainty associated with the risk adjustment and reinsurance programs. From an actuarial perspective, this analysis may be necessary for actuaries to issue unqualified rate certifications[6] that will comply with actuarial standards of practice. States and issuers will need to work together to effectively analyze options, make decisions and simulate the impact of various methodologies.

Within this simulation and analysis, the key decision states and issuers will need to make is whether to use a distributed or a centralized approach.[7] HHS has indicated at least some leanings toward a centralized approach for the federal methodology in 2014 and beyond (it is not clear if this aspect of the federal methodology would also be required for states administering the program). However, a distributed model may be appropriate for analysis and simulation in 2012 and 2013 in states without an existing APCD given the aggressive timelines and necessary issuer cooperation.

Another key decision is how to fund this analysis and simulation. Some states are exploring partnerships with issuer associations given the lack of available state funds, stakeholder interest in this analysis, and timing constraints.

Please see the simulation section (Section 5) for further discussion on approaches and associated timelines surrounding risk adjustment and reinsurance simulation.

2.5 LEVEL OF STAKEHOLDER ENGAGEMENT

While it will be important for states to structure some type of opportunity for stakeholder feedback, each state will need to determine the appropriate level of interaction and input sought from stakeholders. For example, some states may choose to form a stakeholder workgroup, to which many if not all design decisions are delegated. Other states may wish to be more selective in the decisions they delegate or items for which they seek feedback, and may prefer to meet with stakeholders one-on-one. Where individual states fall along this continuum will be dictated by their individual program goals and market structure (and past levels of success with stakeholder engagement).

Please see Section 3 for further information on stakeholder engagement.

2.6 ADMINISTRATION OF THE PROGRAMS

A number of decisions will need to be made regarding the responsibility, authority, and operations of these programs. Section 6 describes these issues in more detail.

2.7 OTHER STRUCTURAL EXCHANGE DECISIONS

A number of other state-delegated decisions may affect the reinsurance and risk adjustment programs including the following:

- Will the state operate a Basic Health Program?
- Will the non-group and small group markets be merged?
- Will employer groups of 51-100 be included in small group prior to 2016?
- What employer options will be allowed within the SHOP Exchange?

A full discussion of the technical impacts of the above decisions to the risk adjustment and reinsurance programs is outside the scope of this paper. However, it is important that the risk adjustment work plan consider the implications of structural decisions.

3. Stakeholder Engagement Plan

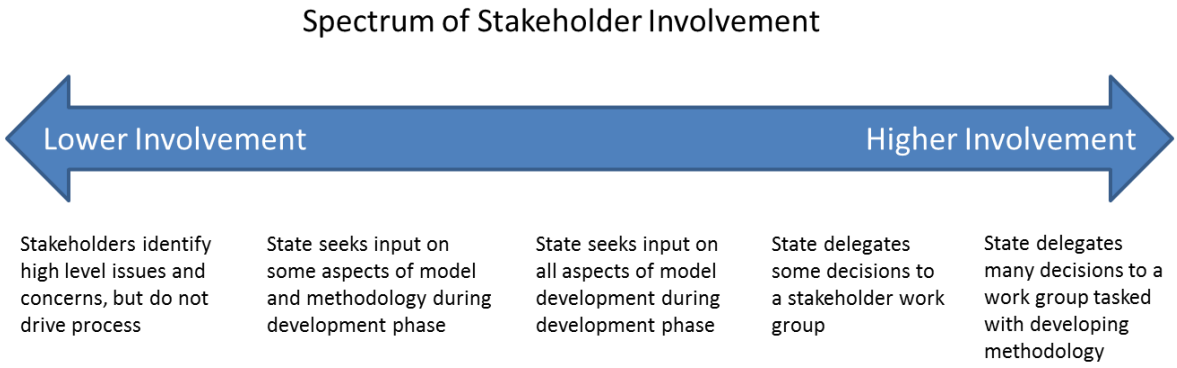
Because the risk adjustment and reinsurance programs are intended, in part, to manage premium costs by allowing issuers to be less conservative when pricing their products, ensuring that stakeholders fully understand and are reasonably comfortable with the methodology adopted by states will be an important element of program success. It is therefore important for states to

[6] Most rate filings require an actuarial certification. A qualified opinion is when the actuary cannot make basic statements required of such filings, without including qualifier language. This language is usually undesirable since it means the actuary has reservations of some sort regarding the soundness of the rates or the rates have a higher than typical degree of uncertainty. Qualified opinions often trigger additional review or other actions.

[7] A distributed approach means health issuers run the model and provide results to the state (or whoever is processing the methodology), while a centralized approach means health issuers submit detailed data and the state (or the state's agent) runs the model and processes the results.

develop a method and process for communicating with and obtaining feedback from stakeholders at different points in the risk adjustment and reinsurance implementation process. Work with stakeholders will need to touch on both methodological and programmatic issues, including design elements of the model, as well as items such as the timing of data refreshes, reporting, and payment schedules. Key milestones are listed below.

The following exhibit highlights the choice states will need to make on the level of stakeholder engagement:



3.1 ESTABLISH STAKEHOLDER WORKGROUP

Some states may wish to create a workgroup of stakeholders to help structure input and feedback into the development of the risk mitigation programs. Having such a forum may help consolidate and streamline the process for providing input, as well as provide a forum for discussion amongst stakeholders about their shared and individual concerns and/or goals for the risk mitigation program. For some issues, however, it may be preferable, either for the state or for individual stakeholders, to provide content in written form or via one-on-one meetings.

The key stakeholders for reinsurance and risk adjustment are obviously the issuers since these programs will affect them significantly. However, providers and other state agencies may be interested in participating. Consumers, navigators and others may have an interest, although education and communication may be the most important aspect of engaging these groups.

3.2 HOLD INITIAL MEETINGS

Including stakeholders early in the process is one approach to make issuers feel that they are part of the process. It could also provide states the opportunity to identify key issues and/or concerns felt in the market with respect to risk adjustment prior to making key design and implementation decisions. Having this information early in the process will allow states to address key issues as part of the program design. Discussion at this point can remain high-level and constitute a sharing of goals, issues, and concerns in the design and implementation of the process, as well as clarification related to the overall timing of key decisions and implementation milestones.

3.3 STAKEHOLDER OPPORTUNITIES FOR FEEDBACK ON MODEL AND METHODOLOGY

Once they have received initial stakeholder input, a state may elect to provide additional opportunities for specific feedback on program design elements as they are developed. The format for accepting feedback, as well as the depth of input requested, will need to be calibrated within each state to reflect the level of input desired by the state.

Options for soliciting stakeholder feedback include conducting a survey focused on certain design elements or implementation issues; holding one or more open meetings to solicit formal or informal stakeholder feedback; soliciting written feedback, either to specific proposals or general questions; or creating a work group. The work group could contemplate broad or narrow participation and be used to either develop recommendations or to provide structured feedback on state proposals.

3.4 FOLLOW UP MEETINGS TO REVIEW FEEDBACK AND COMMUNICATE DECISIONS

Once initial decisions have been made, states will need to develop a way of communicating these decisions to inform stakeholders of the final resolution, elicit further public comment and stakeholder feedback, and provide final opportunities for stakeholders to weigh-in on design and implementation issues. This communication can happen within large or individual meetings, in which the state presents its proposed approach; in a report provided to the market; or in a more formal, regulatory process by issuing draft or final regulations. State communications should make proposed or final design, methodology, and model decisions as clear and understandable to stakeholders as possible to ensure all market participants have sufficient information to make informed pricing and business decisions.

Once a proposed methodology has been selected, an important element of stakeholder communication will be sharing the results of simulations or "dry runs." This will allow both the state and stakeholders to concretely understand the impact of risk mitigation programs on the market as well as on individual organizations.

3.5 ONGOING COLLABORATION

The process for risk adjustment and reinsurance development and refinement will not end after the initial risk adjustment and reinsurance decisions have been made and implemented. Once the programs become operational, the state will need to continue an ongoing dialogue with key stakeholders to ensure the programs are working as intended. States will also make any needed improvements or refinements to program parameters or design issues to reflect unanticipated issues and/or new issues that materialize during the operational phase. Such communication could occur through a stakeholder work group, through ongoing opportunity for comment, or through more informal communication channels with key stakeholders.

4. Scenario Definition

As an accompaniment to this narrative, several sample timelines have been provided which will assist states as they contemplate how best to complete work between now and the 1/1/2014 introduction of the state exchanges. While there are certainly more potential scenarios that are theoretically possible, in the interest of simplicity, only a limited set of the most plausible scenarios have been provided. These scenarios were derived based on a consideration of a spectrum of state decisions and goals.

4.1 KEY FACTORS IN TIMELINE DEVELOPMENT

The timeline for analyzing and implementing risk adjustment and reinsurance depends on numerous issues that will be specifically defined by each state. The most impactful items that will affect the timeline are:

- The state's access to detailed claims data through an All Payer Claims Database (APCD). States that have implemented or are in the process of implementing an APCD would most likely have access to detailed claims data, as long as the APCD was not developed for a specific, different intent with limitations on possible uses. States without an APCD may also have access to data through a specific data request to issuers. (This course of action is covered in more detail in Section 5.2 below);
- The state's interest in exploring an alternative to the federal risk adjustment model ("state alternative");
- The state's interest in developing reinsurance parameters different than the federal parameters;
- The number of issuers participating in a state's individual and small group commercial markets
- Available funding for risk adjustment and reinsurance analysis, stakeholder engagement, and simulations; and
- Issuers' willingness to provide data under a centralized approach or to model results under a distributed approach.

4.2 TIMING CONSIDERATIONS

Setting up any scenario involves working around deadlines in the proposed rules as follows:

- October 15, 2012: HHS is scheduled to release the federal risk adjustment model and reinsurance parameters.
- November 15, 2012: Date for states that want to submit an alternative risk adjustment methodology or alternative reinsurance parameters to submit the model and/or parameters to HHS.
- January 15, 2013: Date HHS will respond to states that submitted alternative risk adjustment methodology or alternative reinsurance parameters.

In addition, the following timing considerations are critical components of developing timelines for all scenarios:

- April 2013: Issuers, and specifically their actuaries and rate-setting teams, must have time to incorporate the results of the risk adjustment and reinsurance projections. Without adequate time, issuers will likely be even more conservative in developing premium rates. Therefore, it is important for issuers to be given enough time to incorporate key assumptions into their pricing. The authors believe issuers would need to be supplied with sound projections of risk adjustment and reinsurance financial transfers before the end of April 2013.
- July 1, 2013: While rate filing requirements and timing varies greatly between states, issuers in all states will need sufficient time to market 2014 products at the new rates. Based on input from issuers, departments of insurance and others, issuers could be expected to be required to submit rate filings for their 2014 plan offerings by about July 1, 2013. Again, this requirement will differ by state, but this assumption has been incorporated into all of the scenarios outlined.

4.3 SCENARIO SPECIFICATIONS

Based on variations in responses to the above issues, the four key scenarios described below have been developed for the analysis and preparation required for 2014:

- Scenario 1: Detailed data used, state considers alternative risk adjustment method, long time frame (i.e. state has begun work or will soon)
- Scenario 2: Detailed data used, state does not consider alternative method, short time frame (i.e. state has not begun work and will not begin soon)
- Scenario 3: Summarized data used, state does not consider alternative method, short time frame
- Scenario 4: Summarized data used, state considers alternative method, long time frame

As discussed throughout this paper, these scenarios are representative of broad situations and approaches. The situation and approach for any given state will vary significantly.

More detail is provided below:

Scenario 1 - Detailed data used, state considers alternative method, long time frame

This scenario assumes that detailed data will be used. The detailed data could come from an APCD or a specific data request to the issuers. The state, or a state subcontractor, would collect and compile the detailed data provided by the issuers and would run the information through the federal risk adjustment model once it is available and at least one other alternative risk adjustment model/methodology. The state or the state's subcontractor would also use the detailed information to simulate financial implications based on various reinsurance parameters. This scenario assumes that states have begun the planning process by November 2011.

Scenario 2 - Detailed data, state does not consider alternative method, short time frame

This scenario assumes that detailed data will be used. The detailed data could come from an APCD or a specific data request to the issuers. The state, or a state subcontractor, would collect and compile the detailed data provided by the issuers and would run the information through the federal risk adjustment model once it is available. The state would not consider an alternative risk adjustment model under this scenario. Even though the state has decided to have HHS administer risk adjustment in this scenario, issuers within a state still need to understand the financial implications of risk adjustment prior to 2014 so that they can appropriately price their products. The state or the state's subcontractor would also use the detailed information to determine the financial implications based on federal reinsurance parameters. This scenario also assumes that states will not begin planning for risk adjustment and reinsurance implications until July 2012 (much later than Scenario 1).

Scenario 3 - Summarized data, state does not consider alternative method, short time frame

This scenario is very similar to Scenario 2 except that Scenario 3 incorporates the concept that issuers will need to do more work and the state (or the state's subcontractor) will do less work than under Scenario 2. In this scenario, issuers will run the federal risk adjustment model and provide specific output from that process to the state. The state will then compile the output from all issuers and release the financial results to all issuers. Similarly for reinsurance, the state will request specific information from the issuers such that once the federal parameters are released, the state can compile the information from all issuers and release financial implications for each issuer. All other aspects of Scenario 3 are the same as Scenario 2.

Scenario 4 - Summarized data, state considers alternative method, long time frame
This scenario is very similar to Scenario 1 except that Scenario 4 incorporates the concept that issuers will need to do more work and the state (or the state's subcontractor) will do less work than Scenario 1. In this scenario, issuers will run the federal risk adjustment model and the alternative risk adjustment model and provide specific output from that process to the state. The state will then compile the results from all issuers and release the financial implications to all issuers. Similarly for reinsurance, the state will request specific information from the issuers such that the financial implications related to various reinsurance parameters can be determined and released to each issuer. All other aspects of Scenario 4 are the same as Scenario 1.

One important point to make is that incorporating adjustments for the currently uninsured population to capture their expected risk (morbidity) will be a critical component of these analyses. All scenarios outlined have assumed that the risk (morbidity) and the general claim level of the currently uninsured population would be incorporated.

There are a couple additional important considerations to keep in mind:

- Short time frame versus long time frame: as with almost any project, the more time allotted to a project allows for more thorough and critical review, and decisions can be based on a more complete picture. However, longer time frames generally imply greater costs to the state because of the additional rigor involved. Also, the political and regulatory environments (e.g. health plans' past willingness to cooperate, legislative calendar, political view of supporting exchange development) may impact this component of decision-making.
- Detailed data versus summarized data: one item to consider is whether or not there would be potential for gaming if the state received summarized information after the issuers run data through risk adjustment models. The potential for gaming may be very limited, but this concept should be discussed in greater detail with states considering this approach.

5. Analysis and Simulations

Issuers will be faced with significant uncertainty with respect to pricing their products in 2014 because of the significant changes under the ACA, including the impact of the risk adjustment and reinsurance programs. Where issuers experience uncertainty, they often increase premium rates or simply choose not to offer products in that market, either of which will protect their organizations from exposure to excessive financial risk. Both reactions are undesirable from a state perspective. No matter how much analysis is completed prior to 2014, significant uncertainty will still exist. However, analysis can be performed which will lessen the uncertainty associated with the risk adjustment and reinsurance programs. From an actuarial perspective, this analysis may be necessary for actuaries to issue unqualified rate certifications that will comply with actuarial standards of practice. States and issuers will need to work together to effectively analyze options, make decisions and simulate the impact of various methodologies.

Pricing actuaries will need three key pieces of information with respect to the risk adjustment program in order to price their products for 2014:

1. What is the risk score of their current enrolled population with respect to the market average?
2. What is the risk score of the currently uninsured population that will become insured in 2014 (most relevant for the non-group market)?
3. What is the average cost of a currently uninsured individual who is expected to join the insurance market relative to individuals currently insured?

In the above questions, risk score and average cost are defined as relative to average members in their rating category (i.e. after accounting for allowable rating variables such as age, smoking status, and geographic area).

Question 3 above is typically included in Level One Establishment Grant proposed activities and is addressed by economists and/or actuarial consultants. The authors are not aware of any states where questions 1 and 2 have been addressed. Therefore, analysis and simulation around those particular questions are necessary. The various approaches and key steps are discussed below.

In addition to the questions related to the risk adjustment program above, health insurance issuer pricing actuaries will need to develop an estimate of the impact of the reinsurance program on non-group product pricing. The state will need to perform careful modeling to determine appropriate reinsurance parameters. If the parameters are set too conservatively or aggressively, the reinsurance program may end up with excessive reserves or shortfalls, either of which could be detrimental to an efficient market.

5.1 MARKET ASSESSMENT

In order to begin the process of assessing both of these programs and deciding on the state's involvement, a detailed understanding of the various state markets and uninsured will need to be developed. Through federal exchange planning grants, many states have performed initial assessments of the impact of the ACA on the various markets, including the impact of previously uninsured entering the market. Analysis of the risk adjustment and reinsurance programs should be integrated with this analysis to the extent possible.

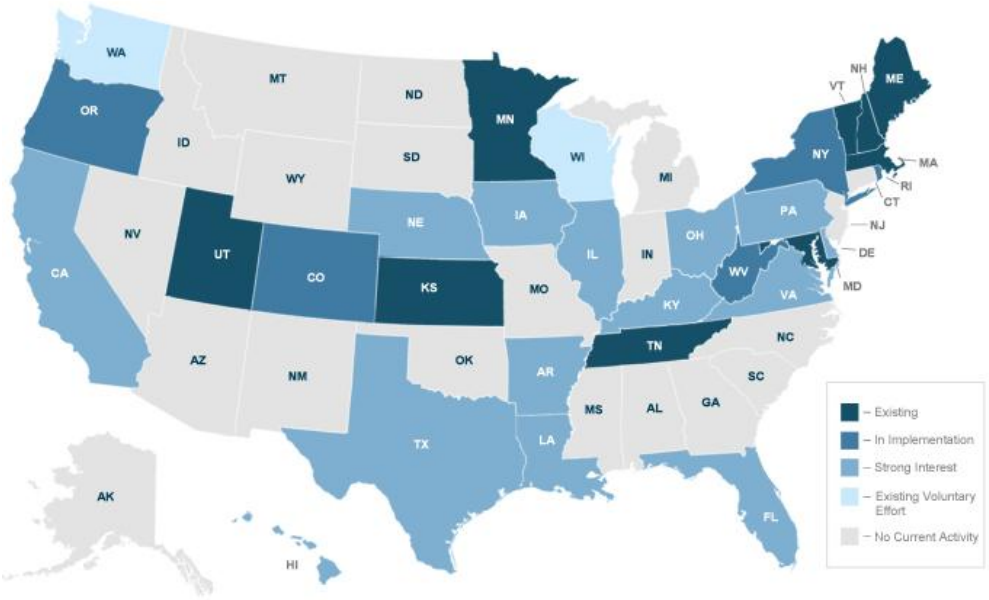
The availability of data and modeling including the following should be evaluated:

- Detailed claims and eligibility for the individual and small group markets (i.e. through an APCD).
- Overall market share for each market (non-group, small group, fully insured group, ASO/TPA, Association, and Medicaid), and by health insurance issuer.
- Currently uninsured and changes in uninsured rates (separated into commercial and other public program migration), high risk pool participation and characteristics, and others.
- Current commercial reinsurance levels for the individual market.
- The availability of rate filings to review current premium levels and rating parameters.

Simulations for both of these programs face a substantial amount of uncertainty due to changes in the insurance markets that will occur beginning in 2014. The introduction of the state exchanges in 2014 will cause movement between market segments, which will be complex to predict based on the large number of factors that will drive consumer behavior. This is contemplated as an integral part of the second simulation.

5.2 STATUS OF ALL PAYER CLAIMS DATABASES (APCDS)

The status of available data will factor into the feasibility of a given work plan for a state, and is therefore important to review in the preliminary analysis. The following table presents the status of efforts around APCDs by state. [8]



[8] Source: APCD Council (www.apcdcouncil.org/).

For states that do not have a currently existing APCD (or one in implementation), having HHS administer risk adjustment may be a more feasible option given the compressed timing. Even for states that have existing APCDs or ones in implementation, seeking exception from minimum data collection rules would involve providing technical specifications and proposed modifications to support risk adjustment and other claims-related activities (HHS 45 CFR 153). The existence of an APCD is less vital for reinsurance.

There are several key questions to be considered if an APCD is to support risk adjustment. The list below is not meant to be exhaustive, but merely to provide a sense of the basic elements needed for implementing a risk adjustment program.

- Data availability: The APCD must have at least a year of data to be useful. The timing of data submission to the APCD and when data become available for use are also important.
- Data format: If a state does not expect to have an operational APCD by Jan 2013, the data that are collected from payers will be subject to minimum data collection rules. The minimum data collection rules specify X12N 837 / NCPDP (pharmacy) format for encounter data submission, and the X12N 834 format for enrollment data.
- Eligibility Elements: There are several elements required for proper risk adjustment, and the full list would vary based on the risk assessment tool that is used. These include (at a minimum):
    - Unique member identifier that needs to be consistent across claim and enrollment information, as well as across products within an issuer and across issuers. Typically, consistent identifiers such as Social Security Numbers (SSNs) are submitted by issuers to a warehouse where they are encrypted into a different yet still consistent and unique ID.
    - Coverage spans that allow calculation of months of eligibility by coverage type and also distinguish whether or not the individual had a medical/pharmacy benefit during that time. Risk assessment tools typically take into account partial months of eligibility so that the scores are not biased.
    - Age, gender, coverage type and other demographic information.
- Claim Elements: Risk assessment tools typically vary in terms of what information is required from encounter data in order to run the software. Some widely used adjusters require very little information to run - namely diagnosis codes, national drug codes (NDCs), service dates (in order to correctly identify experience periods), unique member identifier, and procedure codes (CPTs). Procedures codes are typically not used in the adjuster software itself. However, they are valuable in excluding diagnosis codes from diagnostic services that introduce false positives and are therefore susceptible to gaming.

The following tables (parts A & B) highlight key information required by risk adjustment and whether existing APCDs currently contain this information.

Table A: Status of key fields related to risk adjustment (MA, ME, VT, TN, KS)

Description	Massachusetts	Maine	Vermont	Tennessee	Kansas
First service date available in APCD	Jan 2008	Jan 2004	Jan 2007	Jan 2009	At least 2004
Level of edits / checks employed for acceptance (Low, Medium, or High)	High	med-high	med-high	At least medium	At least medium
Level of checks employed after acceptance for use (Low, Medium, or High)					
Data Element Inclusion					
Required demographic fields captured (age or DOB, gender, region or zip code)	Yes	Yes	Yes	Yes	Yes
Can connect eligibility and medical claims with unique member ID	Yes	mostly	mostly	Yes	Yes
Can connect eligibility and pharmacy claims with unique member ID	Yes	mostly	mostly	Yes	Yes
Can create eligibility spans	Yes	Yes	Yes	Yes	Yes
Number of diagnosis codes collected (maximum)	13	13	13	13	9
Pharmacy data included	Yes	Yes	Yes	Yes	Yes
Pharmacy NDC Code included	Yes	Yes	Yes	Yes	Yes
One record per coverage *span* or for each month of coverage	Per Month	Per Month	Per Month	Yes	Yes
Status information like disability included (include footnote with references)	No	No	No	No	No

Table B: Status of key fields related to risk adjustment (UT, MN, MD, NH)

Description	Utah	Minnesota	Maryland	New Hampshire
Date APCD was or will be available	2010	July 1, 2009	Varies[1]	2005
First service date available in APCD	Jan. 2007	At least Jan'08		At least 1/1/2005
Level of edits / checks employed for acceptance (Low, Medium, or High)	At least medium	At least medium	Low-Med	High
Level of checks employed after acceptance for use (Low, Medium, or High)				
Data Element Inclusion				
Required demographic fields captured (age or DOB, gender, region or zip code)	Yes	Yes	Yes	Yes
Can connect eligibility and medical claims with unique member ID	Yes	Yes	Partially[2]	Yes
Can connect eligibility and pharmacy claims with unique member ID	Yes	Yes		Yes
Can create eligibility spans	Yes	Yes	Yes	Yes
Number of diagnosis codes collected (maximum)	8	12	Yes	13
Pharmacy data included	Yes	Yes	Yes	Yes
Pharmacy NDC Code included	Yes	Yes	Yes	Yes
One record per coverage *span* or for each month of coverage	Yes	Per Month	Per Coverage	Per Month
Status information like disability included (include footnote with references)	No	Yes[3]		

1. Medical data available since early 1990s, pharmacy added around 2000, eligibility added in 2011
2. Not able to track movement across products / plans.
3. Product code indicates 'disability' or 'disability benefits'

5.3 RISK ADJUSTMENT SIMULATIONS

Simulations for both of the programs being reviewed face a substantial amount of uncertainty due to changes in the insurance markets that will occur beginning in 2014. The introduction of the state exchanges in 2014 will cause movement between market segments, which will be complex to predict based on the large number of factors that will drive consumer behavior.

A centralized approach to simulations means that a central agency would run the risk adjustment simulations using detailed claims and eligibility data. A distributed approach would still require a central agency to perform many of the functions of a simulation. However, instead of the central agency running detailed claims and eligibility through a risk adjustment model, issuers would run the model and provide member level or summary level results to the central agency.

Centralized Approach

A centralized approach to risk adjustment simulation would generally require an existing APCD or a fast moving collaborative effort on the part of issuers to supply detailed claims and eligibility data. This approach would require the state to run the data through a risk adjustment tool and produce reporting, some of which would be shared with the plans. The minimum data required to run a typical risk adjustment tool are discussed under Section 5.2, however the exact fields needed would vary by the tool that is used.

Centralized simulations would require more resources from the administering entity. The entity could develop the capability (i.e. staff, equipment, licensing, etc.) to run the risk adjustment analytics, or hire external expertise. The main steps involved would be specifically:

- Engaging issuers, collecting detailed eligibility and claims data, and premium data and rating factors
- Applying checks, thresholds, or edits to data, ensuring consistency in formats
- Loading data into a database system
- Preparing input files for a risk assessment tool
- Running the tool and producing detailed risk reports broken out by (amongst other things) market segment, plan, and demographic/eligibility categories

As discussed earlier, the main purpose of simulations is to inform pricing of products in 2014. While the rate filing deadline may vary by state and/or products, it is assumed for the purposes of timelines in this paper that the deadline for filing rates would be in July 2013. This means that information from simulations would need to be shared with plans as early as April

2013. In a centralized approach very detailed reporting on the underlying morbidity risk of the covered population would be available to the exchange. This information would be useful for a variety of purposes, for example producing risk adjusted cost and utilization metrics, planning for future exchange initiatives, monitoring levels of adverse selection within the exchange and financial impact to issuers, and preparing for any disruptive changes in access of care. However the information that needs to be provided to plan pricing actuaries would be limited to the overall relative risk profile (possibly at other levels of detail including product or network and area). The state should also provide issuers with reporting showing the drivers of differences from the average risk (for example, a higher prevalence of individuals indicated with cardiovascular disease).

Another purpose of a simulation is to inform the decision on whether to use the federal risk adjustment methodology or an alternative methodology. This, of course, assumes that a state is considering an alternative methodology. Interest in an alternative methodology may be driven by a number of factors including what data to use, factors to apply, timing, phased in approach, etc. The very first round of simulation using an alternative model would give the state information on whether this approach would be feasible. For example, if the cost of running the analytics is too high, or the data are inadequate, or the model produces inconsistent or unreasonable output – the state may decide to discontinue with the alternative model approach. In a centralized approach, on the one hand, the state could apply the alternative methodology more consistently across issuer data; however, it would consume time and resources.

Conversely, the state may decide that this is the approach they wish to pursue and prepare to submit an application to HHS to certify the alternative methodology in early November 2012. According to guidance from HHS, a state would have 30 days to consider the federal model (that is assumed to be a part of the *advance annual federal notice of benefit and payment parameters*).

Distributed Approach

A distributed simulation approach would not require an existing APCD or issuers to submit detailed claims and eligibility data. However, this approach would not allow the state to validate the data by comparing it to benchmarks or comparing it across organizations. Certain methods could be employed to lessen these issues, but there would likely be bigger concerns compared to the centralized approach. The more detail provided by issuers under this approach, the higher the quality of the results and understanding of the results would be. For example, if issuers returned member-level information including risk markers for each member, the state could not only tell each issuer how their overall risk profile compared to the market average, but they could tell each issuer what was driving differences in the average (for example, a lower prevalence of diabetes or a lower prevalence of individuals taking medications associated with heart disease).

The distributed simulation approach would require access to a risk assessment model by all plans submitting this information. Ideally, the access should be free of cost and should minimize administrative burden to the state, which is a key consideration in approving an alternative methodology. To the extent the model is easy to understand, simple to use, and transparent, it would help ensure appropriate application across plans. The model should provide diagnostics on each run so that any obvious errors are promptly identified. Such diagnostics can include the proportion of individuals not grouped in any category, percentage of members with medical encounters and/or pharmacy encounters, the average length of eligibility of a member in a calendar year, the proportion of diagnostic diagnoses excluded from scoring, etc. Additionally, any model that operates on elements that are fairly consistent across issuers would be better under this approach. For example, the meaning of a diagnosis code does not change across issuers, however if an approach makes a distinction between professional and inpatient codes, the way these services are categorized may vary across organizations and introduce a layer of uncertainty in results.

This approach can include requiring a certification from the plan actuary regarding the appropriate use of the model and furnishing information that is accurate and complete to the best knowledge of the actuary. This may increase the likelihood of obtaining data that has undergone more review and scrutiny.

5.4 REINSURANCE SIMULATIONS

Both initially in 2012-2013 for the 2014 calendar year reinsurance program and annually thereafter, the reinsurance program financials will need to be reviewed in-depth to ensure fiscal soundness. The goal of reinsurance simulations is to ensure that the national contribution rate will appropriately cover projected reimbursements. This will allow a state to draw its own conclusions about the adequacy of the national contribution rate, and ultimately drive a decision by a state as to whether or not they should alter the federal assessment rate and create a state-specific assessment. According to the proposed rules, states

have the option of increasing the assessment due to concerns about inadequacy or the desire to fund administrative expenses, but may not decrease it. They can also alter (or remove) certain reinsurance parameters. The actual surplus/deficit of the program realized will also be heavily influenced by the risk profile of its residents in the individual market which drives the level of claims being reimbursed in the state.

The first simulation will likely model projected cash flows of the reinsurance program with static population estimates and parameters proposed by HHS. It is expected that relative health of the residents enrolling in individual plans will have a major effect on the level of reinsurance that can be afforded by the parameters. All else being equal, if a state's individual market enrollees have a higher risk profile relative to the nation as a whole, then the average federal contribution may result in much lower parameters than other states. The second simulation contemplated in the timeline will focus on incorporating expected population migrations as a result of the ACA. Key considerations in projecting post-migration program expenses are heavily dependent on the following assumptions:

- Current proportion of health insurance premiums (fully insured) or medical claims (self-funded) in the individual market versus all insurance markets including individual, small group, large group, self-insured groups, Medicaid managed care, Medicare managed care, and others. The larger the current individual market share relative to the overall market, the lower the reinsurance levels afforded by an average contribution.
- Similar to the above, states with a greater than average proportion of currently uninsured residents would drive an even higher proportion of individual insurance market premiums in 2014. This rapidly expanding individual market in 2014 would result in less money available for claims reimbursement, thus lowering the overall effect of the reinsurance contributions on that market. This may be a function of the attractiveness of the individual market plans offered in the state exchange and their ultimate level of subsidies, which is beyond the scope of this review.
- Rate of expansion of the public programs and integration of such plans within the state exchanges could also alter the premium proportions by market segment. If more of the uninsured have the ability to move to public programs, then this will decrease individual market costs which will affect coverage options.

The simulations contemplated above should be conducted as frequently as possible to monitor the potential for a deficit emerging in that first year. The frequency of calculations for 2015-16 will be dependent on the state's preferences and the accessibility of data from the reinsurance administrator and/or market issuers. These reviews will need to continue through 2018 as this is how long the pools will remain open, although the final years would only entail a projection and estimate of runout claims, not assessments (unless the program were extended as proposed rules allow). There could also be questions as to the eventual use of any surplus left over at the end of the program, given that Incurred But Not Reported (IBNR) reserves starting in the end of 2016 will need to be conservative to allow for the variability in late-reported claims.

5.5 KEY SIMULATION DELIVERABLES

For risk adjustment, states should be able to create the following deliverables as a result of the simulation:

- Report to state entity governing risk adjustment illustrating the results of applying a risk assessment model on collected data from issuers. The results will include an average risk score for issuers which will allow the state entity to simulate risk adjustment payment calculations. Detailed results will include prevalence statistics and data diagnostics that will provide further insight into drivers of risk and data quality. Summarized relative risk scores will be shared with issuers providing critical input towards actuarial pricing of health insurance products in 2014 and 2015.
- Expected payable/receivable adjustment by carrier. This involves applying the risk score factor output mentioned above and normalizing for ratable factors (e.g., age). This also involves incorporation of baseline premium with possible adjustment for items such as geography and actuarial value of plan designs.
- Recommendation on whether or not to utilize a state model versus the federal model, and whether to administer the program locally.
- Explicit identification of expected deficit/surplus projected from risk adjustment, if expected, to be factored into the following year's contribution rate will need to be included in reports for late 2015-16 starting in late 2014.
- Publication of the risk adjustment model proposed to be used. The federal government proposes that states that plan to modify federal parameters (national in scope) issue their notice by early March in the calendar year before the effective date.

From the reinsurance side, output associated with the simulation would include the following:

- Report to state entity governing reinsurance on expected range of financial results under various scenarios for premium levels, national premium assessments, migration assumptions, reinsurance parameters, and health status.
- Recommendation on whether or not to create a state-specific assessment rate based on factors identified above based on range of likely results.
- Explicit identification of expected deficit/surplus to be factored into the following year's assessment will eventually have to be included in the report as well.
- Estimate of IBNR for the program.
- Publication of assessment rates different than national rates is required. The federal government proposes that states that plan to modify federal parameters issue their notice by early March in the calendar year before the effective date.

5.6 FILING WITH HHS

The proposed rules included minimum criteria for a state-based risk adjustment methodology. States can also modify the reinsurance parameters, but may not modify the structure of the reinsurance coverage.

The proposed rules provide some minimum criteria for the model including performance similar to or better than the federal model. If a state decides to develop its own risk adjustment model or adjust the federal weights, it needs to do so at least as often as the federal model is updated.

State models must meet criteria based on principles that guided the creation of the hierarchal condition categories (HCC) model used in Medicare Advantage risk adjustment, including:

1. Accurately explains cost variation;
2. Chooses risk factors that are clinically meaningful to providers;
3. Encourages favorable behavior and discourages unfavorable behavior;
4. Uses data that are complete, high quality and available in a timely fashion;
5. Provides stable risk scores over time and across plans; and
6. Minimizes administrative burden.

HHS is requiring risk adjustment activity reports in the year after the benefit year showing average actuarial risk for each plan, the charges and payments, and likely additional information. While not stated in the proposed rules, likely information might include prevalence reports showing the drivers behind differences in the results and normalization factors. The authors expect HHS to develop a standardized report, allowing states the ability to include additional information. The report structure would need to be able to accommodate state-specific risk adjustment methods and models.

All of this information will need to be filed with HHS in November 2012. However, some of this information, including support of the predictive nature of the state's alternative model, can be prepared in advance. The biggest challenge will be adapting the methodology and reporting to information emerging from HHS since the first time states may see some of the federal methodology's details will be in October 2012. The authors also expect HHS to be somewhat flexible in the November 2012 submission regarding details that are affected by information released in October 2012.

6. Administration and Governance

The current draft regulations contemplate a significant role for states in the administration of both the reinsurance and risk adjustment programs. These functions can be run from the exchange or by another entity within the state. Funding for the reinsurance program can be included in the assessment from issuers, meaning no additional state or federal funding will be required to manage the program. However, the risk adjustment program, similar to other ACA responsibilities such as granting exemptions to the individual responsibility requirement, will create an expenditure that must be supported through exchange funding or another financing source. Of the two programs, the reinsurance program is less operationally complex, while risk adjustment represents a more comprehensive commitment from the state. Key elements and considerations related to the administration and oversight of the risk adjustment and reinsurance programs are discussed in this section.

6.1 DETERMINE PROGRAM GOVERNANCE AND OVERSIGHT

When establishing a risk adjustment or reinsurance function, the state must first decide where the function will reside and who will govern it. Risk adjustment and reinsurance functions managed by the state can be overseen by the exchange or by another public agency within the state. The decision-making process for establishing a governance structure will be driven both by an assessment of existing capacity for data collection, analysis, and related regulatory oversight functions, as well as a strategic and policy assessment of where these functions best fit within the overall structure of health care reform. The exchange has a dual role that encompasses functions analogous to a private company as well as regulatory and oversight functions more similar to a government agency. Although at times advantageous to play both roles simultaneously, finding the appropriate balance can be challenging. Some states may elect to combine both types of functions within the exchange; others may seek to differentiate purely regulatory functions from more market-oriented functions.

In the case of risk adjustment and reinsurance, some states may elect to leverage another entity to oversee the program's administration, such as the Insurance Department, the Medicaid agency, the high risk pool administrator, if one exists, or another state entity with relevant experience applying and collecting health issuer assessments. For risk adjustment, many state Medicaid programs currently operate risk adjustment models as part of their Managed Care programs, and in many states, Insurance Departments collect information on products, pricing, and financial performance. For reinsurance, there are some states that manage high-risk pools and other similar subsidized pools that may have relevant experience to manage the tasks. It is possible that a state which self-manages a high-risk pool would have the internal capabilities to collect premium assessments at a minimum. Depending on whether there are assessments on self-funded plans, states may also have a strong sense of the overall premiums (for fully insured plans) and claims (for self-funded plans) to which the contribution rate will be applied.

6.2 PROGRAM FINANCING

State options and requirements for financing the administrative aspects of risk adjustment and reinsurance programs differ between the start-up/development period (prior to 2014) and the operational period (2014 and beyond). In the pre-2014 start-up period, the state will incur costs to develop the infrastructure and functionality of the programs, as well as conducting initial analysis, simulations, and stakeholder outreach, but will not have an ongoing, dedicated revenue stream.

In most cases, financing for these initial development and implementation expenses can be sought through Exchange Establishment grants from CMS. In cases where program elements will benefit the state's Medicaid program, costs will need to be allocated between programs and sought separately through a Medicaid Advanced Planning Document (APD), which are financed 90 percent through the Centers for Medicare and Medicaid Services (CMS). Once operational in 2014, states will need to develop an ongoing revenue source to support the administration, staffing, and ongoing maintenance of the programs.

Proposed regulations allow states to increase the reinsurance assessment to finance the administration of the reinsurance program, so no additional state or federal funding is required for the operation of the reinsurance pool. For risk adjustment, no such assessment is provided in the regulations, so states will need to develop a financing mechanism to support the program's operations. As they do for financing the exchange, states have options with respect to a source of funding. One approach is to place the administration of the risk and reinsurance programs in the state exchange and use establishment grant funding to design, develop, and build the required infrastructure. Ongoing cost can be included in the funding mechanism used to finance the exchange (e.g., an assessment on participating QHPs or on the entire market). For states that use risk adjustment in their Medicaid Managed Care program or another state agency, further efficiencies and cost offsets can be achieved by leveraging the newly developed exchange function to calculate and administer the Medicaid Managed Care risk program. If the state pursues this option, they will need to develop the required inter-agency financing structure to support the added cost borne by existing staff and/or technology resources.

To determine the appropriate structure and financing source, as well as to assess the overall feasibility of supporting state administration of this function, the state must first assess the overall cost level required to run the risk adjustment program. While this cost will differ from state to state, some key cost drivers for the ongoing maintenance and operations of the program will be the resources needed to staff and maintain the collection and storage of data; staff resources to perform ongoing reporting and analysis; staff resources to perform important plan management and communication functions; software licensing and updating costs; vendor costs in cases where key functions are outsourced; and actuarial and consulting fees for the development and analysis of program models and parameters.

The total cost of managing this program will vary considerably depending on several factors:

- Existing resources the state can rely upon, such as an existing APCD. The ability to leverage an existing data infrastructure will significantly reduce the cost to the state.
- Existing familiarity with risk adjustment models in other state programs such as Medicaid Managed Care.
- The level of state-specificity that states choose to pursue, including whether they wish to develop both their own model and administrative methodology, rely on the federal methodology but reweight based on a state-specific population, or rely on the federal model and only implement a state-specific payment adjustment methodology.
- The size of the insurance market and the number and variety of issuers and products sold in the state. Risk adjustment will be far more complex and time-consuming for states with more than 10 licensed issuers than for states with fewer issuers.

6.3 ESTABLISH ADMINISTRATIVE INFRASTRUCTURE – RISK ADJUSTMENT

Risk adjustment will require the state to access, store, and analyze large volumes of enrollment and claims data. Because risk adjustment will impact the entire individual and small group health insurance markets, collecting these data will be a substantial task for any state. States choosing to develop and administer this program will need to develop the capability to intake, cleanse, standardize, securely store, and analyze large volumes of issuer claims and enrollment data. Key elements of this activity will include the acquisition of data warehousing hardware and software, with a dedicated staff to support the management, analysis, and reporting of this information, as well as the inevitable back-and-forth with issuers to ensure data accuracy and integrity. Other key requirements will include software licensing, maintenance, and updates, as well as developing the IT infrastructure and connectivity required to interface with issuers not only for the acquisition of claims and enrollment data, but also for information related to product rating and premium amounts.

Establish Data Warehouse and Reporting Capacity

States that do not have an existing APCD but want to administer the risk adjustment program will need to establish a data warehouse to store claims, as well as the system interfaces and management resources to accept, scrub, standardize, and maintain the integrity and quality of the data. Given the volume of enrollment and claims information states will need to house in this repository, the development, population, and management of such a database may be the single biggest and most costly task facing states contemplating the administration of their own risk adjustment program. States will need to carefully assess where they can leverage existing database platforms, where they will need to develop a new structure, what the cost of such an endeavor will be, and how it can be funded. Many states will incorporate the development of this warehouse in their Establishment Grant funding request, but the impact on state financing depends in part on how the proposed program governance structure and whether or not the warehouse will integrate with existing state programs such as Medicaid.

In addition to robust data warehouse to support ongoing operations, the state will need to develop a data solution for preliminary planning and analysis, as well as the development of initial simulations. While these can be performed without the full functionality of a robust data warehouse, any interim solution contemplated will still require the accumulation of large volumes of claims and enrollment data and the capacity to analyze and report on this information.

Establish Key Vendor Relationships

Many states that elect state risk adjustment will elect to outsource portions of the risk adjustment program, including the hosting and maintenance of the data warehouse, ongoing reporting and analytics, as well as the development and ongoing updates of risk adjustment parameters, models, and model weights. In addition, states will need to identify and procure the necessary software packages to apply risk scores to individuals and issuers. Engaging this outside support will require time to be built in for RFP development and vendor selection.

Ongoing maintenance and operations

Once the state has gone live with the risk adjustment program, dedicated fulltime resources will be needed to ensure its successful implementation. Elements that the state will need to continue to monitor include: (a) data integrity concerns (enrollment and claims); (b) software updates to the risk adjustment tool; (c) creation of internal and external reports; and (d) issuer management. It is important to note that in addition to maintaining the database infrastructure and analysis, there will be important roles in communicating with issuers and engaging in ongoing interaction to address issues, field concerns, and communicate decisions and results.

6.4 DEVELOP ADMINISTRATIVE INFRASTRUCTURE – REINSURANCE

The oversight and administration of the reinsurance pool will require two types of functions. First, a policy-setting function related to setting parameters, issuing regulations, monitoring compliance, and reporting results to the market. Secondly, an administrative function focused on funds collection, management, and disbursement, as well as the development of policies and processes to ensure sound financial stewardship. Critical functions to manage this program include the establishment and periodic modification of reinsurance parameters; assessment collections and cash management; claim intake (summary level) and payment; analysis and reporting; and claims auditing.

Some of the key specific functions include the following:

- Specify source data for premiums (fully insured) and claims (self-funded) to which the national "contribution rate" will be applied.
- Define mechanism for issuers and TPAs to submit these contributions to the state.
- Establish process and methodology to audit premiums and claims on which the contributions were assessed, particularly with TPAs submitting as a percent of "total medical expenses."
- Collect contributions.
- Define data required for submission of claims for reimbursement based on HHS guidelines, for non-grandfathered plans only.
- Remit the Treasury Department's portion of the reinsurance contributions back to the federal government.
- Complete detailed financial analyses and projections on the current and expected future federal contributions, attachment point, coinsurance rate, and reinsurance cap.
- Communicate methodology via a "state notice."

Identification or Establishment of Non-Profit Reinsurance Entity

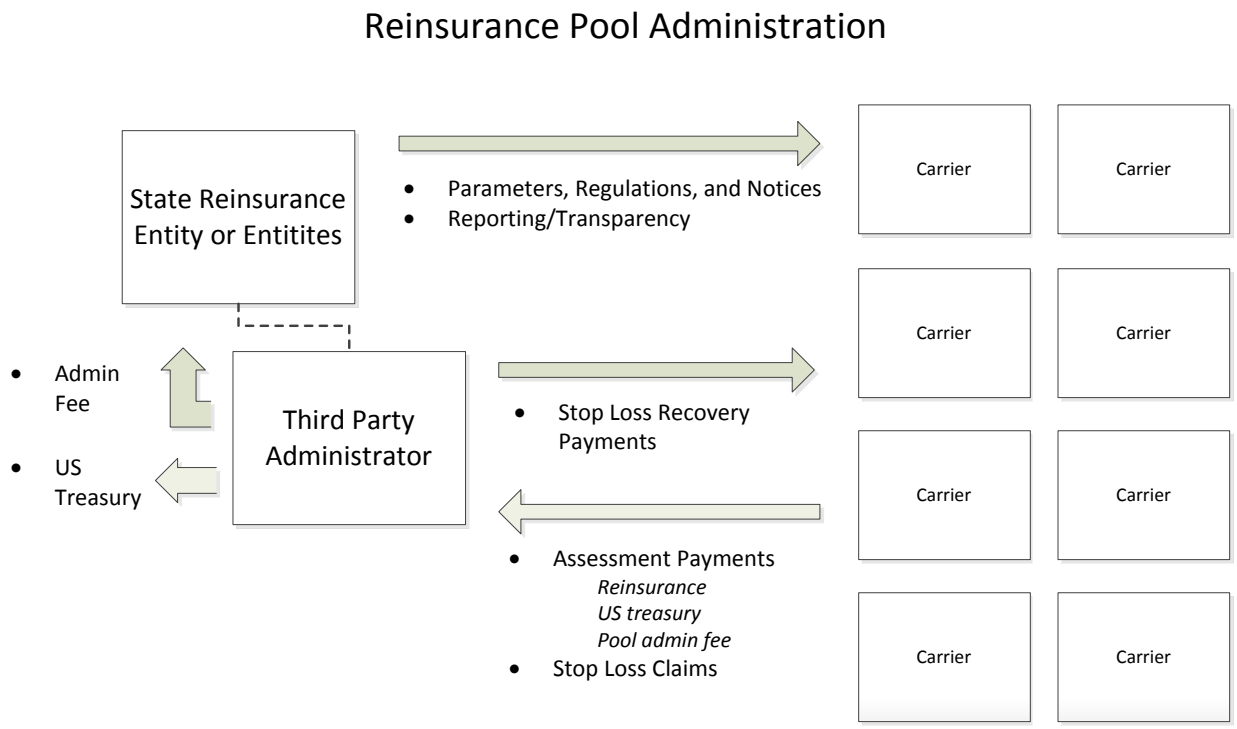
The regulations require the establishment of a reinsurance entity, or the designation of an existing, non-profit reinsurance entity to carry out the provisions in the law. While the regulations suggest delegating this task to an independent non-profit entity, the regulations leave room for the possibility that this function can be overseen and managed by a state agency.

HHS has stated that it is permissible for a reinsurance entity to subcontract certain administrative functions as long as the state reviews and approves the contracts. The reinsurance entity will still remain the ultimate party responsible for all functions, but this will likely make it easier in the event that the state needs to set up a reinsurer.

In addition, the regulation states that while a state can set up two administrators, this will likely lead to additional cost. They also indicate that this would only be permitted in the event that the reinsurance entities cover distinct geographic areas, which would require a state notice indicating this.

Identify and Contract with Third Party Administrator

Some states will elect to administer the reinsurance pool utilizing existing internal staff resources, but most will probably elect the use of a third party administrator to run the operations of the pool. The state will therefore need to provide for the time required to issue an RFP and establish the operational interfaces needed to get the TPA integrated and up and running when making plans to establish the program.



Claims Reimbursement Specifications

There are several major outstanding issues related to claims that have yet to be defined by HHS. The three most relevant issues are:

- the level of data required for reimbursement;
- definition of claims eligible for reimbursement; and
- reimbursement time frames.

HHS specifies that the reinsurance administrator will need to collect all data required to make payments, and that this will be provided in state notice and federal notice. Given the potential for reinsurance reimbursements at lower attachment points to be comprised of a large number of individual claims, providing data could be a non-trivial exercise especially if there is a requirement to meet certain electronic submission standards. On the other hand, as one of the program goals is "administrative simplicity," it would be logical to require the same amount of data as is required by commercial reinsurers.

In draft regulations, HHS has defined that only "essential benefits" will be reimbursable under the program. NAIC has strongly suggested that this is an unnecessary complication such that claims should be reimbursed on an "as paid" basis for simplicity. Looking to the Early Retiree Reinsurance Program (ERRP) for potential precedence, all major issuers and consulting houses were required to create specific programs to clearly segregate claims reimbursable by Medicare as eligible for reimbursement. Additionally, there should be a clear definition as to whether fees and claims "credits" such as Utilization Management (UM) program fees, Disease Management (DM) program fees, percent of claim network fees, and pharmacy rebates should be considered as a part of "total medical expenses."

A final claims issue is the specification of a reasonable turnaround time for claims reimbursement, which is directly related to what happens if the reinsurance program runs out of money for reimbursements mid-year. Similarly, HHS asked for comments on a maximum time frame to report claims, after which they will not be eligible for reimbursement, in order to cap the liability for a claim at a certain time period. They suggested a six-month time period consistent with Medicare, but this still appears to be an open question, which may be dependent on a particular state's method for dealing with overpayments in the program.

6.5 ESTABLISH FUNDS FLOW MECHANISMS AND CASH MANAGEMENT PLAN

Both the reinsurance and risk adjustment programs will require governing authorities to collect money from and make disbursements to issuers. In the case of reinsurance, the state will be collecting money from all issuers, including self-insured plans, and making payments to issuers participating in the non-group market who submit valid claims for reimbursement from the pool. In the case of risk adjustment, the state will be collecting money from lower-risk plans and making payments to higher-risk plans. Supporting these cash management requirements has three key components: (1) financial management infrastructure and control; (2) timing of payments and collections; and (3) managing over and under collection of funds.

Financial Management Infrastructure and Reporting

The entities governing both risk adjustment and reinsurance functions authority will need a basic financial management infrastructure, including dedicated bank accounts and/or specified state funds, an accounting function to track funds and support public reporting, and the systems necessary to support making and accepting electronic payments. For reinsurance, the governing entity will be collecting funds from issuers on a regular basis and storing these funds to apply to future pool recoveries. Thus, the reinsurance authority should plan to provide periodic ongoing reporting to reflect total collections, recovery payments, and existing balance in the pool, as well as an annual report at settlement to reflect total collections and disbursements. For risk adjustment, most states will not be collecting money throughout the year in anticipation of future payouts, so ongoing reporting will be less intensive. However, the capability to accept, make, record, and report on electronic transactions will be necessary functions to support the program.

Timing of Payments and Collections

Under reinsurance, the state is required to ensure that payments to issuers cannot exceed collections, while risk adjustment is intended to be budget neutral, with collections balancing payments. While the proposed regulations do not establish specific timing requirements for the collection and disbursement of funds, establishing a schedule to ensure the state expends only monies that have been collected is an important aspect of program administration.

For risk adjustment, the proposed regulations contemplate a final settlement to occur six months following the end of a calendar year. Once calculations have been finalized, the state will need to collect money from plans determined to have lower risk members and, subsequent to collecting monies, making payments to plans determined to have higher risk members.

For reinsurance, the proposed regulations anticipate a more regular frequency of stop loss claims submissions and recovery payments, with final settlement to occur at a six-month lag from the end of the period. In this program, the state or its contracted vendor must develop a process to ensure that payments do not exceed collections during the year. A variety of options exist to achieve this, such as delaying payments for reinsurance claims until the last six months of the year when sufficient reserves have accumulated to sustain ongoing payments. There is also a widespread desire to collect funds sufficiently early to allow for claims reimbursement starting in February 2014. While HHS has proposed that contributions be collected monthly starting in January 2014, this may be difficult. Given the administrative burden of sending in monthly assessments, the NAIC has suggested that they be collected quarterly, in advance, based on anticipated premiums and claims. While this could work, it would also not be without challenges.

Managing Over and Under Collection of Funds

It is likely that in either risk adjustment or reinsurance, collections will be lower than payments.[9] States have a variety of options for managing the over or under collection of funds relative to claims, but the intended methodology for managing this issue should be clarified to the market prior to implementation to enhance certainty and transparency for issuers to set prices.

For risk adjustment, the possibility exists that charges collected will not be sufficient to cover payments, or vice versa. To achieve budget neutrality, the state will need to determine whether to reduce payments, increase charges, or both. In the event that charges exceed payments, the state will also need to decide whether to hold a reserve to stabilize future years, or adjust

[9] While risk adjustment is intended to be budget neutral, depending on whether the state elects to settle these payments on a regional basis or whether final normalization is used to effect budget neutrality, there may be instances in which collections and payments do not tie out precisely. See CCIIO Draft White Paper http://cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf and "Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment" http://www.rwjf.org/coverage/product.jsp?id=72682 for further details, including proposed options for distributing shortfalls/excess funds.

payments and/or charges to balance the pool to zero.

For reinsurance, the state is not permitted under federal regulations to disburse more in recoveries than it collects in assessments. It is contemplated, however, that they may collect more from issuers than is paid out in recoveries in 2014, 2015 and/or 2016. For the under-collection scenario, states will need to develop an approach, which could include, for example, (a) reducing recovery payments on a pro-rata or other basis to limit payments to the amount collected or (b) retrospectively increase assessment values to cover the full value of recoveries. In the over-collection scenario, states may be able to hold excess collections in reserve to off-set future shortfalls, or the regulations contemplate the possibility that states will adjust parameters in the following year to ensure any excess collections are paid out during that year.

It should also be noted that states are afforded the flexibility to adjust reinsurance parameters to manage the timing of collections and payments, which may be a cash management and stabilization tool. While the regulations set forth a targeted amount of funding to collect and disperse as part of reinsurance, states are able to alter the time frame within which these amounts may be collected. For example, a state could establish parameters in order to collect more money in year 1, thereby ensuring its ability to cover claims, and then adjust parameters in year 2 to spend down any reserve that accumulated.

6.6 DEVELOP REPORTING AND TRANSPARENCY PLAN

Risk adjustment and reinsurance will both affect the premiums that issuers charge and how they adjust historic experience to develop pricing under reform. Therefore, it is important for issuers to receive information on the risk adjustment methodology and estimates of their risk scores for their current population under the proposed risk adjustment approach. This timeline should be exposed to the issuers for feedback to ensure it is consistent with their pricing cycle.

6.7 ESTABLISH DATA REVIEW AND AUDIT PROGRAM

In many Medicaid programs, an informal process of reviewing and validating encounter data takes place between issuers and the state. This process typically involves member level risk scores and risk markers being provided by the state to the issuer, and some back and forth regarding data and results. In some instances, this process results in material corrections and improvements to the risk adjustment results. However, even if no issues are found or changes made, this process usually increases the comfort level in the methodology, data, and results.

CMS has begun Risk Adjustment Data Validation (RADV) Audits in the Medicare Advantage programs, which are audits of issuer-submitted diagnosis codes. Audits are completed on a relatively small sample of claims, and diagnoses that are not supported are excluded from a recalculation of the risk adjustment factors. The impacts on revenue, on a retrospective basis, can be significant – easily exceeding typical issuer profit margins.

The audit process proposed for risk adjustment under the ACA appears to be closer to RADV audits, with notable exceptions. However, many details are pending regarding available funding mechanisms, technical aspects, and allowable state flexibility. This work plan does not focus on this task given the uncertainty and because the timing is not as critical as other steps. However, the audits will require significant state resources for states that decide to operate the risk adjustment function and is therefore an important component of the overall decision-making process. In addition, discussing audits with stakeholders will be important.

For reinsurance, as with any self-reported assessment program, states will need to ensure that there is compliance through audits. Of particular concern with this program is the fact that a portion of the contributions will now be based on self-funded claims, which may not have been previously monitored. Therefore, the audit function will need to consider that self-funded contributions will be collected from Third Party Administrators (TPA's) and any employer/funds/trusts acting as their own TPA if they process their own claims. As it relates to the contribution, HHS has stipulated that fully insured plans use "earned premium" as a base. The self-funded portion only states that it will be applied based on "total medical expenses." It is reasonable to assume that these expenses will be defined consistent with other legislation on minimum loss ratio, for example. At issue is whether "claim-like" expenses such as medical management or utilization management fees are excludable.

7. Other Timeline Considerations

7.1 LEGISLATIVE ISSUES

A state may need legislative action if it does not have authority to use currently available data for needed purposes or if it needs the issuers to provide data or analyses to the state. Some examples where legislative action may be needed include the following:

- If the state has an APCD but is not authorized to use it for the needed purposes
- If the state does not have an APCD and there is concern with all issuers complying with a voluntary state data request
- If the state plans to use a distributed model for the risk adjustment simulation and there is concern that issuers will not comply without a statutory requirement

If a state needs legislative action to have authorization to use an APCD, there may be no alternative to going through the legislative process. But if the legislative action is needed to ensure issuer participation, the state could decide to forego going through the legislative process with the expectation that issuers will still participate, particularly since it is in their own best interest to do so given the results will help them in their future pricing.

Some considerations when determining whether to go through the legislative process include:

- Timing – if they go through the legislative process, states will need to wait to start the process of collecting or using the data until the legislation has passed. This could delay the start of the process up to six or more months.
- Resources – getting legislation written, passed and implemented will take time and resources away from other crucial reform work.
- Comprehensiveness – getting legislative authority will provide full participation of the issuers, allowing for the most comprehensive analysis. If there is no legislative authority and only a portion of the issuers participate, the information should still be of value, but the value will depend on the portion of the market that participates.
- Quality – getting legislative authority may encourage issuers to provide more accurate and complete information, particularly if they otherwise may not understand the importance or intent of the request.

Note that, as part of the legislative process, it is recommended that the state involve the issuers early on. While there is a need to balance the information shared to keep the process quick and efficient, communication with the issuers should have the goals of being informative, limit opposition with the legislature, and should enable issuers to prepare for legislative requirements.

7.2 COORDINATION WITH MLR, RISK CORRIDOR, AND OTHER ACA PROVISIONS

There has been considerable discussion regarding the interaction of reinsurance, risk adjustment, minimum loss ratio requirements, and risk corridors. While the interdependencies between these various programs are important from a modeling standpoint, they are less important from an operational standpoint.

In CCIIO's draft on "Risk Adjustment Implementation Issues," inter-dependencies were briefly mentioned. The main issue they identified was that certain issuers could potentially "double dip" by receiving reinsurance payments and risk adjustment payments for high-risk individuals. There was a brief discussion as to how a state might incorporate reinsurance payments in an alternative risk adjustment model, but no conclusive proposal as to the best manner to incorporate.

As it relates to the federally-administered risk corridor program, HHS has proposed that all cash flows from both the reinsurance and risk adjustment programs should be considered. This will reduce the ability of issuers to potentially "game" the system.

Operationally, risk adjustment and reinsurance will need to be finalized before the Medical Loss Ratio (MLR) and federal risk corridor provisions can be applied. Therefore, the sooner risk adjustment and reinsurance activities are completed, the sooner MLR and risk corridor provisions can be applied. The timeline scenarios developed here are fairly aggressive regarding completing risk adjustment and reinsurance activities.

The most important issue may be the impact of risk adjustment and reinsurance audits. If HHS intends for MLR and risk corridor provisions to be applied after the effects of audits (or be applied before audit and then adjusted after audits) and the three year limit on audit completion is used, then final reconciliation for MLR and risk corridor programs may take several years to complete.

8. Risk Adjustment Implementation

Implementation of risk adjustment is complex, but feasible given past successes by many state Medicaid programs. The issues included in this report should assist states in thinking through issues that apply in 2014 and beyond.

8.1 TECHNICAL IMPLEMENTATION ISSUES

An important component of risk adjustment implementation is the exact way in which payments are calculated and the timing of their transfers. ACA legislates that payments are charged on plans with an actuarial risk that is below average, and that these payments are made to plans with risk that is above average. In terms of risk scores, a plan's actuarial risk is relative to the average risk score for the state/market/program baseline.

Payments will generally be calculated by multiplying a 'baseline premium' with the actuarial risk for a plan. The payments will be budget neutral at the state or program level. Two issues that need consideration are (a) what is the 'baseline premium,' and (b) how to make the charges and payments add up to zero (i.e. be budget neutral)?

The CCIIO whitepaper discusses various options in these and other related technical areas.
(http://cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf)

8.2 RISK ADJUSTMENT IMPLEMENTATION BEGINNING IN 2014

Prior to 2014, simulations and projections focus on providing plans with enough information so that they can price their 2014 plans properly. Beginning in 2014, simulations become reality, and the focus moves to implementation and cash flow. In this section, main objectives, important considerations to be addressed when choosing a methodology, action required of issuers and the exchange, and the associated timeline around particular methodologies that could be employed are discussed.

It is important to realize the following objectives with respect to the risk adjustment program:

1. The exchange needs to provide issuers the type of information they will need to determine premiums and financial statement entries appropriately.
2. Data problems will exist and may significantly affect risk adjustment results. The state should work with the issuers to resolve data issues to the extent possible.
3. Provide results to issuers in a timely manner.
4. Minimize cash flow disruptions for the issuers. More frequent, updated analysis of risk adjustment results will help support this objective.

SCENARIOS FOR 2014

There are different options that could be employed by a state in 2014 after careful consideration of the items discussed above, and based on approval by HHS. The following is a list of three possible options for implementation. Others options exist as well; these three options are intended to provide ideas around the general concepts of timing and process.

Option A: Interim Method Beginning Later

This option is displayed in our post-2014 timeline and involves the following components:

1. Medical claims data for the first six months of 2014 with three additional months of claims payments would be collected in October 2014.
2. The Exchange would analyze the information submitted, calculate the interim payments (receivables and payables), and collect and distribute payments in the following three months.
3. In April 2015, medical claims (perhaps alongside pharmacy claims) would be obtained for dates of service in 2014. A concurrent, medical claims-based risk adjustment model is applied to the 2014 claims. This step incorporates the first payment distribution for enrollment in the latter half of 2014 and also adjusts payments

made and received for the experience in the first half of 2014. Final payments for 2014 experience would be distributed in August 2015.

Option A: Interim Risk Model is consistent with final risk model		
	Implementation Step	**Timing**
1	Health plans submit 1st half of 2014 data, with 3 months of run-out	Oct 2014
2	Exchange calculates and reports interim payments (in and out)	End of November 2014
3	Exchange collects interim payments from low-risk carriers	Dec 2014
4	Exchange distributes interim payments to high-risk carriers	Jan 2015
5	Health plans submit full year 2014 data with 3 months of run-out	Apr 2015
6	Exchange calculates and reports final payments (in and out)	End of Jun 2015
7	Exchange collects final payments from low-risk carriers	Jul 2015
8	Exchange distributes final payments to high-risk carriers	Aug 2015

While not shown on this timeline, a state can choose to perform monthly calculations (amounts paid and received) once initial risk scores are assigned to members. This process would allow payments to be made more frequently between January 2015 and August 2015. Monthly calculations would be based on shifts in enrollment rather than incorporation of new diagnosis data. As with any risk adjustment method, members without a sufficient amount of enrollment would obtain a default risk score (perhaps a demographic score or the plan's average risk score for other members).

Option B: Interim Method with More Refinement

Similar to Option A, this option also incorporates interim risk adjustment payment distributions during 2014 and final reconciliation in mid-2015. The unique feature of Option B is that risk scores for the people who were insured prior to 2014 would be based on medical data in 2013. The risk scores for people who were previously uninsured and are new to the market in 2014 would be based on a pharmacy-only model. Toward the end of 2014, the interim payments for all 2014 members could begin to be based on medical data. This option would allow interim payments during 2014 to begin earlier within the year than other options. However, the methodology used for the interim payments would differ from the model used for the final payment and therefore, significant adjustments to payments upon reconciliation in 2015 could occur. Also, HHS has concerns about the use of pharmacy data for risk adjustment purposes, so pending further guidance, it is not clear if incorporation of pharmacy claims data will be an allowed approach.

The following table provides a general timeline for this option.

Option B: Interim Risk Model incorporates 2013 medical data and 2014 Rx data		
	Implementation Step	**Timing**
1	Health plans submit 2013 medical data and 1st quarter of 2014 Rx data	May 2014
2	Exchange calculates and delivers interim risk scores and makes payments	Jun 2014 - Aug 2014
3	Health plans submit 2nd quarter of 2014 Rx data	Aug 2014
4	Exchange calculates and delivers interim risk scores and makes payments	Sep 2014 - Nov 2014
5	Health plans submit 2014 medical data to-date	Nov 2014
6	Exchange calculates and delivers interim risk scores and makes payments	Dec 2014 - Feb 2015
7	Health plans submit full year 2014 data - **medical**	Apr 2015
8	Exchange calculates and delivers final risk scores and makes payments	Jun 2015

Option C: No Interim Model

This option would be the easiest to incorporate because it is simply the final step of Options A and B, meaning there would be no interim payments distributed throughout 2014. Payments would not be distributed until the June to August 2015 time frame. The main disadvantage of this option is the delay in the transfer of payments. Another disadvantage is the large payable and receivable amounts that issuers will be obligated to keep on their books throughout 2014, and as of December 31, 2014 in particular; not only will the magnitude of these figures be very large for some issuers, there will be an extremely high degree of uncertainty in the associated underlying assumptions.

2015 AND BEYOND

There are different approaches that can be taken in 2015 and beyond regarding implementation of risk adjustment but, in general, the more the markets stabilize in terms of people covered, the methodology incorporated can also stabilize. It is anticipated that there will continue to be an influx of currently uninsured people into the market in 2015 as the penalty for remaining uninsured will increase, but not as much of an influx as will be seen in 2014. In 2016, it is anticipated an additional influx of new members into the market as the penalty is increased again; however, in years after that, it is expected the markets will experience a minimal influx of new members due to the individual mandate.

Particularly while a significant number of people are entering the market, continuing to have final risk adjustment payment distributions based on a concurrent model using that particular year's diagnoses is recommended. The timeline provided contains an example of how risk adjustment could be implemented for 2015. In general, it consists of the following main components:

1. Interim analysis: Using 2014 claims data available in April 2015, a prospective approach would be applied and risk adjustment payments would be calculated.
2. Monthly calculations and payment distributions between the interim analysis and the final reconciliation: Using the member-specific risk scores determined in the interim analysis and subsequent enrollment data showing movement of members, the risk adjustment payments for issuers would be re-calculated on a monthly basis.
3. Final reconciliation: This will be based on 2015 medical (and perhaps pharmacy) claims data and a risk adjustment model with concurrent weights.

8.3 CONCLUSION

The Affordable Care Act provisions fundamentally change the rules of the health insurance marketplace. The risk adjustment and reinsurance provisions of the ACA are critical risk mitigation tools, necessary to create an efficient and robust market. CCIIO, states, health plans, consumers, providers and other stakeholders need to work together to make reform successful. A substantial amount of this collaborative effort needs to take place on these specific programs and on healthcare reform more generally before 2014 as outlined in this paper.

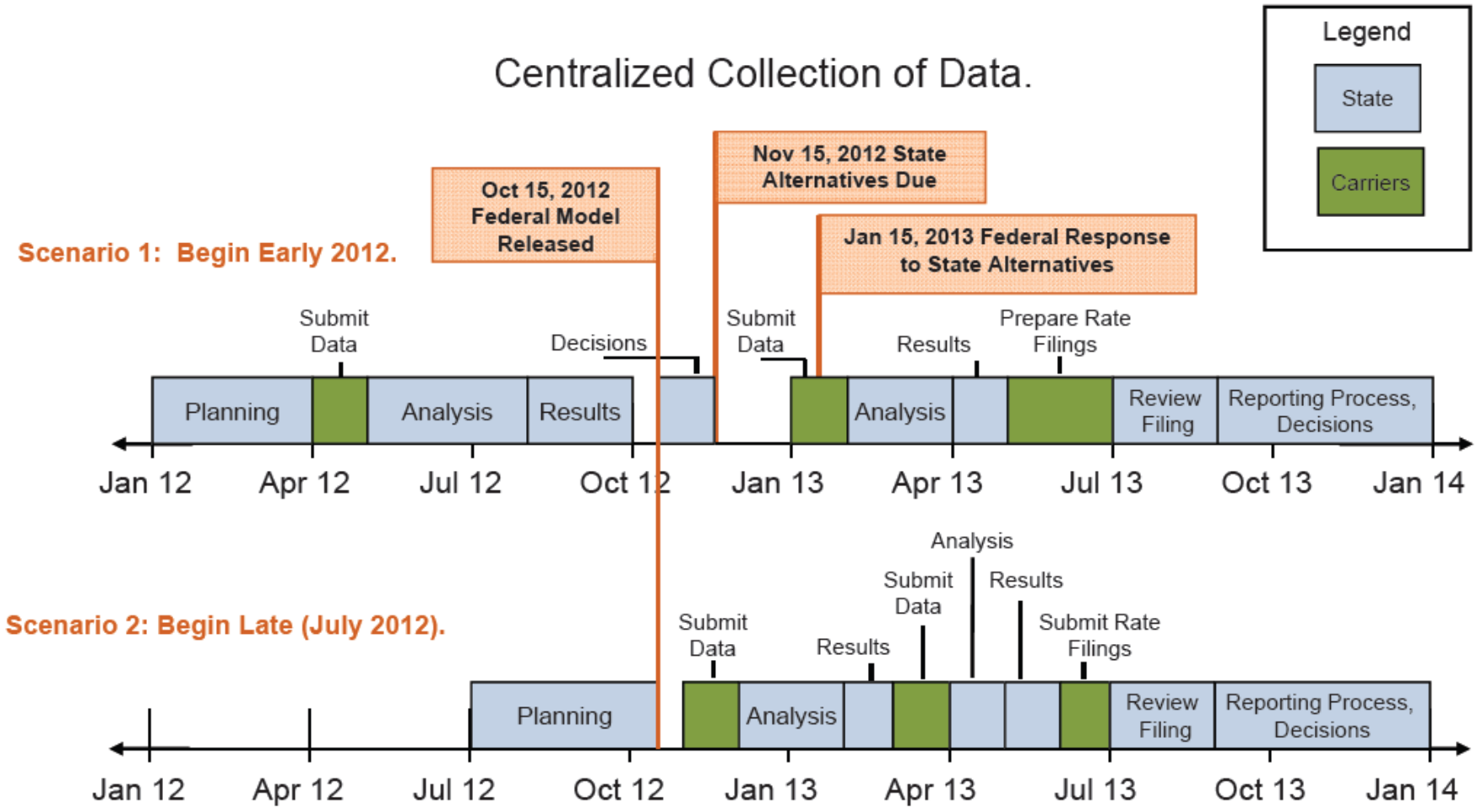
ABOUT THE PROGRAM
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.rwjf.org/coverage.

ABOUT WAKELY CONSULTING
Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage.

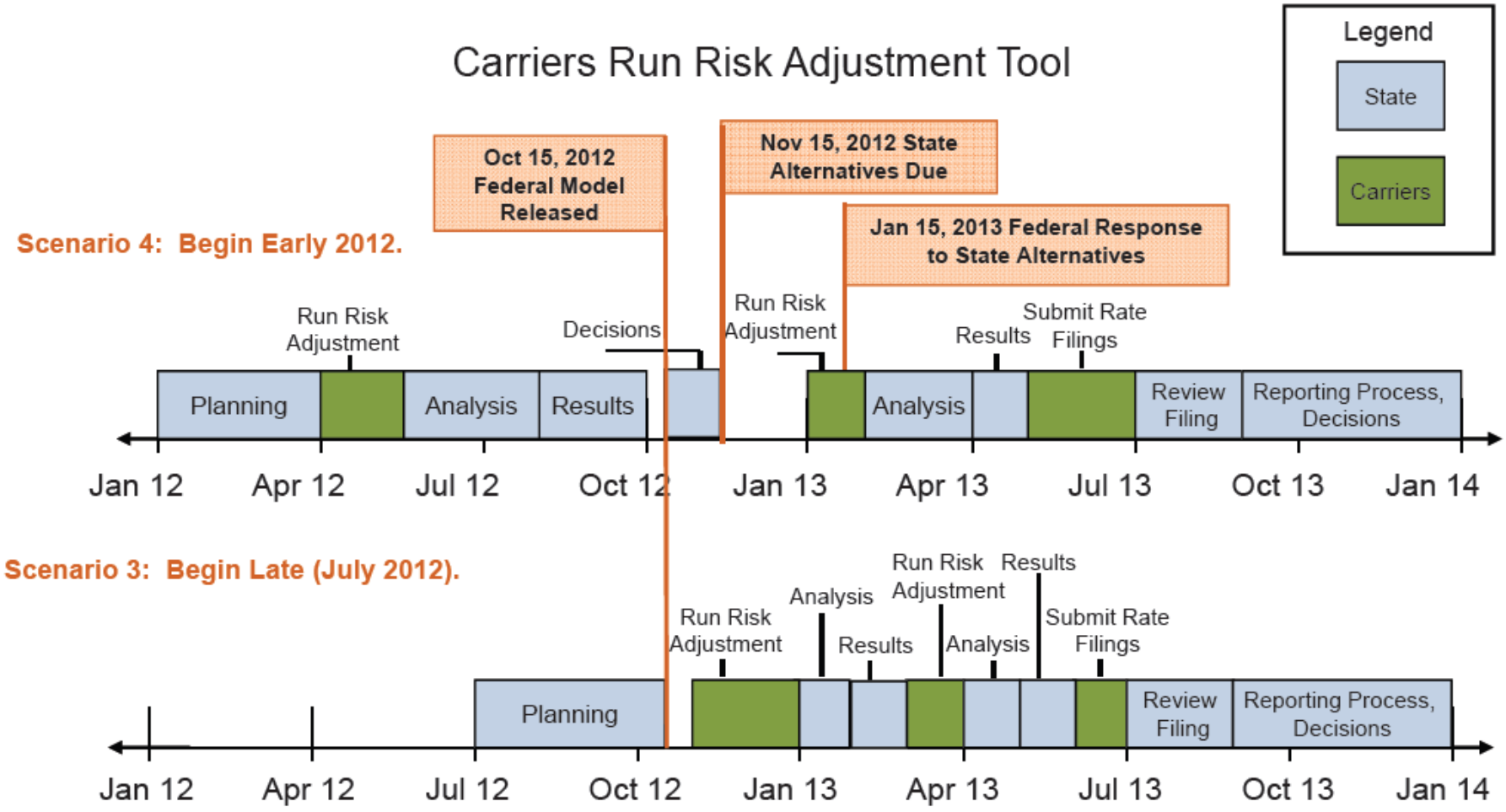
ABOUT THE ROBERT WOOD JOHNSON FOUNDATION
The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measureable and timely change. For nearly 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit *www.rwjf.org*.

For more information, please contact Ross Winkelman at RossW@Wakely.com or at (720) 226-9801.

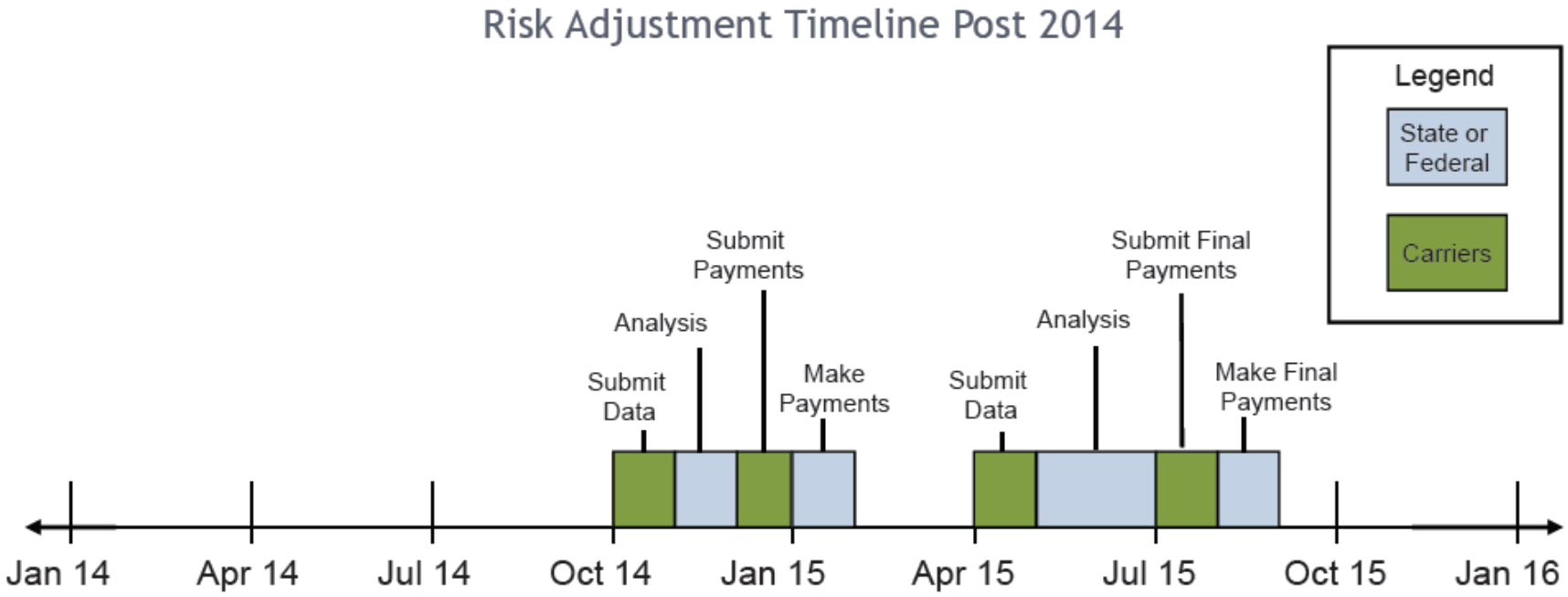
Appendix A - Risk Adjustment and Reinsurance Timeline Prior to 2014



Appendix A - Risk Adjustment and Reinsurance Timeline Prior to 2014



Appendix A - Risk Adjustment and Reinsurance Timeline Post 2014



Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 1: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State is considering alternative methodology and parameters, relatively early start-date (October 2011)						
1	Market survey	*Identify market share and collected premium for all individual/small/large group carriers in state as well as self-funded plan TPAs; collect contact information*	*Analysis & Simulations, Section 5.1*	*State: Request from the Division of Insurance*	10/15/2011	11/15/2011
2	Establish Risk Adjustment and Reinsurance (RARE) Workgroup	*States may choose to set up a task force for the purpose of coordinating initial activity for risk adjustment and reinsurance, although management of reinsurance and risk adjustment will likely fall to other current state entities or the state exchange. This entity will tap into personnel knowledgeable in specific fields (e.g. information technology, data privacy, liaison with legislative/regulatory authorities).*	*Program Governance, Section 6.1; Stakeholder Engagement Plan, Section 3*	*State: Key state agencies establish RARE Workgroup*	10/15/2011	11/30/2011
3	Develop estimates for administration costs and an administrative financing model to support risk adjustment and reinsurance	*If risk adjustment not financed through assessment, develop alternative financing to support preliminary studies and eventual risk adjustment administration (reinsurance can be supported through their assessments on premiums and claims)*	*Program Financing, Section 6.2*	*State: RARE Workgroup*	10/15/2011	11/30/2011
4	Assess data handling capabilities	*1. Equipment / Staffing* *2. Vendor contracting* *3. Software licensing* *4. Hardware requirements (data storage)*	*Risk Adjustment Administrative Infrastructure, Section 6.3*	*State: RARE Workgroup with IT expert from Medicaid or outside contractor issues report under several options (state maintains / vendor contracting etc.); HIX Director of Human Resources*	10/15/2011	11/30/2011
5	Assess reinsurance capabilities and eligible reinsurers in State	*ACA requires a not-for-profit reinsurer to administer the program. Administrative functions may still be outsourced and should be reviewed as part of vendor contracting assessment.* *1. Premium collection and Treasury submissions* *2. Claims adjudication and reimbursement* *3. Ability to respond within defined timeframes*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: RARE Workgroup with IT expert from High Risk Pool or possibly outside contractor to issue report on cost/feasibility under several options (state maintains / vendor contracting etc.); HIX Director of Human Resources*	10/15/2011	11/30/2011
6	Develop data request for risk adjustment and reinsurance	*1. Develop data dictionary of elements to be collected* *2. Provisions for privacy and cross-plan/time member identification* *3. Data formatting*	*Analysis & Simulations, Section 5*	*State: RARE Workgroup / outside contractor, HIX General Counsel*	10/15/2011	11/15/2011
7	Develop data collection schedule and data auditing procedures	*1. Threshold procedures for data quality,* *2. Mechanism to accept/reject records,* *3. Data re-submission timeline* *4. Data extension period (60 assumed in this workplan),*	*Analysis & Simulations, Section 5; Data Review and Audit, Section 6.7*	*State: RARE Workgroup / outside contractor*	10/15/2011	11/15/2011

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 1: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State is considering alternative methodology and parameters, relatively early start-date (October 2011)						
8	Establish Risk Adjustment and Reinsurance Stakeholder Workgroup	*Some states may wish to create a workgroup of stakeholders for risk adjustment, reinsurance, or both in order to help structure input and feedback into the development of the risk mitigation programs. Having such a forum may help consolidate and streamline the process for providing input, as well as to provide a forum for discussion amongst stakeholders about their shared and individual concerns and/or goals for the risk mitigation program. This is more relevant for risk adjustment versus reinsurance due to the higher level of complexity.*	*Stakeholder Engagement, Section 3.1*	*State: HIX Executive Director*	10/15/2011	11/15/2011
9	Communicate draft data collection schedule to carriers, invite comment	*Good to solicit feedback on feasibility of submission schedule, however may not be able to change it much. Good to know ahead of time if a large carrier(s) will be unable to submit information, and to figure out ways to address it*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	11/15/2011	12/15/2011
10	Revise data collection schedule, auditing procedures based on critical feedback		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: RARE Workgroup, Stakeholder Workgroup*	12/15/2011	12/31/2011
11	Communicate data collection schedule and auditing procedures to carriers	*Send data request out, but simultaneously draft pending legislative/regulatory changes. This should give carriers more time to put data together.*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	1/1/2012	1/31/2012
12	Investigate alternative risk adjustment methodology and state-specific reinsurance parameters	*Federal model will not be available for either program. States will need to decide their risk adjustment methodology based on alternative model / white paper and HHS model's white paper and stakeholder feedback / expert assessment. For reinsurance, states will need to model various alternatives without the benefit of knowing HHS' assessment rate.*	*Key Decisions, Sections 2.2 - 2.3; Analysis & Simulations, Sections 5.3 - 5.4*	*State: Stakeholder Workgroup*	10/15/2011	11/30/2011
13	Develop preliminary proposal of a possible risk adjustment methodology (and timeline) to be shared with carriers	*1. Prospective / Concurrent* *2. Data elements used by the model* *3. Mechanics and timing of risk adjustment* *4. Develop rating variables / cohorts (e.g. are children under 1 a separate category?)* *5. Integration with geographic rating variable* *6. Integration with risk corridor calculation / timing*	*Key Decisions, Section 2.2; Simulation Deliverables, Section 5.3 and 5.6*	*State: RARE Workgroup + expert consultant + HIX Executive Director + Stakeholder Workgroup*	11/15/2011	1/15/2012
14	Develop preliminary proposal of possible reinsurance parameters (and timeline) to be shared with carriers	*1. Coinsurance rate* *2. Attachment point* *3. Reinsurance cap* *4. Timing of assessments and claims payments* *5. Alternatives to deal with deficit/surplus*	*Key Decisions, Section 2.3; Simulation Deliverables, Sections 5.4 and 5.6*	*State: RARE Workgroup + expert consultant + HIX Executive Director + Stakeholder Workgroup*	11/15/2011	1/15/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 1: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State is considering alternative methodology and parameters, relatively early start-date (October 2011)						
15	Solicit comments from carriers on alternative risk adjustment methodology and potential state-specific reinsurance parameters		*Stakeholder Engagement, Section 3.3; Simulation Deliverables 5.6*	*State: HIX Chief Commun. Officer*	12/1/2011	12/31/2011
16	Regulatory changes to data submission requirements	*Note that these are changes to existing regulation around data collection in light of work on, primarily, risk adjustment data needs*	*Legislative Timeframes, Section 7.1*	*State: RARE Workgroup, HIX Executive Director*	1/1/2012	3/31/2012
17	Distribute preliminary proposal of risk adjustment methodology and reinsurance parameters (and timelines) to carriers		*Stakeholder Engagement, Section 3.3; Scenario Definition, Section 4;*	*State: HIX Chief Commun. Officer*	1/15/2012	1/15/2012
18	Meet with stakeholder workgroup(s) to discuss purpose and upcoming process		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: RARE Workgroup, HIX Executive Director*	1/15/2012	2/15/2012
19	Communicate the program specifics with RARE Workgroup after meeting with carriers		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Executive Director, HIX CFO, other senior staff*	2/1/2012	2/29/2012
20	Distribute data request to carriers / stakeholder workgroup for both risk adjustment and reinsurance	*This will be the second distribution of the data request and collection timeline, this time with finalized regulation mandating compliance.*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	2/1/2012	2/29/2012
21	First round of data collection for risk adjustment (up to 60 day extension on deadline)	*CY2011 experience, paid through 4/1/12*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	4/1/2012	4/30/2012
22	First round of data collection for reinsurance	*CY2011 premiums and claims, paid through 4/1/12*	*Analysis & Simulations, Section 5*	*State: HIX CFO, HIX manager of finance and analytics, expert consultant*	4/1/2012	4/30/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 1: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State is considering alternative methodology and parameters, relatively early start-date (October 2011)						
23	Analyze the potential impact of uninsureds	*This can be done through a simulation approach, generating scenarios of low/high impact to results from round 1. The assumptions underlying such an analysis need to be transparently communicated to carriers.*	*Analysis & Simulations, Sections 5.3 - 5.4*	*State: HIX CFO, HIX manager of finance and analytics, expert consultant*	4/1/2012	4/30/2012
24	Produce Round 1 of reinsurance simulations based on agreed upon parameters	*1. State/contractor reviews expected premiums (FI) and claims paid (SF)* *2. Data reconciliation checks (financials)* *3. State/contractor reviews expected claim reimbursements* *4. Includes review of uninsured entering market*	*Key Decisions, Section 2.2; Reinsurance Simulations, Section 5.4*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	5/1/2012	7/31/2012
25	Produce Round 1 of risk adjustment results based on agreed upon methodology to determine impact on each carrier	*1. State/contractor runs risk adjustment model on data* *2. Data reconciliation checks (financials)* *3. Data quality diagnostics, especially those relating to risk adjustment* *4. Prevalence reports*	*Key Decisions, Section 2.2; Risk Adjustment Simulations, Section 5.3*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	5/1/2012	7/31/2012
26	Provide results from Round 1 to carriers	*Summary results only, score relative to all carriers, prevalence for carrier. Separately show an exhibit with low/high simulated scenarios for the impact of uninsured population movement in 2014*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	8/1/2012	8/31/2012
27	Meet with carriers interested in understanding their own results more and addressing data concerns		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: Stakeholder Workgroup*	9/15/2012	10/15/2012
28	Make recommendation on whether to use federal or alternative risk adjustment methodology. Present results from Round 1 to RARE Workgroup and make final decision.		*Simulation Deliverables 5.6*	*State: HIX Executive Director, HIX CFO, other senior staff*	10/1/2012	10/31/2012
29	Release of federal Risk Adjustment Model and "advance" Reinsurance Parameters	*The timeline assumes that the required date to file alternative risk adjustment methodology will be 1 month from the release of the federal model*	*Simulation Timing, Section 5.5*	*HHS*	10/15/2012	10/15/2012
30	Analysis of the federal reinsurance parameters. Present results to RARE Workgroup and make final decision.	*Run federal model on collected data, compare performance, included data, other aspects to the alternative model. Compare financial impact on each carrier under HHS and alternative model.*	*Simulation Deliverables 5.6*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	10/15/2012	11/15/2012
31	Prepare and share results from federal model with stakeholder workgroups. Present results to RARE Workgroup and make final decision.	*The timing here is very short. These results can be shared through a meeting / web-ex approach and input is collected. The exchange takes the decision to either pursue an alternative methodology, or adopt HHS model*	*Simulations, Sections 5.3 - 5.4; Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Executive Director, HIX CFO, other senior staff*	10/15/2012	11/15/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 1: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State is considering alternative methodology and parameters, relatively early start-date (October 2011)						
32	If decide to not use federal model, file alternative risk adjustment methodology and/or alternative reinsurance parameters with HHS		*Filing with HHS, Section 5.7*	*State: HIX Chief Commun. Officer*	11/15/2012	11/15/2012
33	File request for exception from minimum standards for data collection. Operational APCD on or before January 1, 2013 is exempt from minimum data collection standards for risk adjustment		*Filing with HHS, Section 5.7*	*State: HIX Chief Commun. Officer*	12/15/2012	12/31/2012
34	HHS to inform State if alternative method for risk adjustment and/or reinsurance has been accepted		*Simulation Timing, Section 5.5*	*HHS*	1/1/2013	1/15/2013
35	Second round of data collection	*Experience with dates of service through 9/30/2012, paid through 12/31/2012. This round is used to provide carriers information for 2014 pricing.*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	1/1/2013	1/15/2013
36	Prepare and share results from round 2 with carriers / stakeholder workgroup	*Summary results only, score relative to all carriers, prevalence for carrier. Separately show an exhibit with low/high simulated scenarios for the impact of uninsured population movement in 2014*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	1/15/2013	2/28/2013
37	Respond to carrier questions related to Round 2		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	3/1/2013	3/31/2013
38	State to provide notice of intent to local stakeholders that they will use alternative models, if applicable.		*Simulation Timing, Section 5.5*	*State: HIX Chief Commun. Officer*	3/1/2013	3/31/2013
39	Present results from Round 2 to RARE Workgroup		*Simulation Deliverables 5.6*	*State: HIX Executive Director, HIX CFO, other senior staff*	4/1/2013	4/30/2013
40	Establishment of process, procedures, and schedules for collection of reinsurance assessment on premium (FI) and paid claims (SF)	*1) Collect assessments to support claims and administrative costs* *2) Submit Treasury's portion of assessments* *3) Timing to be established after federal input*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: HIX CFO, outside contractor, although still waiting for federal guidance on these items*	4/1/2013	6/30/2013
41	Establishment of process, procedures, and schedules for reimbursement of reinsurance claims	*1) Reporting requirements for reimbursement* *2) Methods to receive/manage/store data submission* *3) Timing of expected reimbursements* *4) Method of reducing payment in case of reimbursements exceeding payments*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: HIX CFO, outside contractor, although still waiting for federal guidance on these items*	4/1/2013	6/30/2013

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 1: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State is considering alternative methodology and parameters, relatively early start-date (October 2011)						
42	Develop accounting procedures, funds flow diagrams, and cash management infrastructure for reinsurance program		*Accounting Funds Flow & Cash Management, Section 6.5*	*State: HIX CFO, reinsurance entity / outside contractor*	4/1/2013	6/30/2013
43	Other key date: carriers to submit rate filings for 2014 premiums (approximate)		*Simulation Timing, Section 5.5*	*Carriers*	6/1/2013	6/30/2013
44	Develop reporting protocols and schedule back to State, carriers, and TPAs; including processes and procedures for auditing		*Reporting & Transparency Plan, Section 6.6*	*State: HIX CFO, reinsurance entity / outside contractor*	7/1/2013	9/30/2013
45	Testing of processes and procedures established for collection of assessment and claims reimbursements		*Accounting Funds Flow & Cash Management, Section 6.5*	*State: HIX CFO, reinsurance entity / outside contractor*	7/1/2013	9/30/2013
46	Third round of data submission (30-day window)	*CY2013, paid through 4-1-14. This round is used to provide carriers information for 2015 pricing*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	4/1/2014	4/30/2014
47	Prepare and share results from round 3 with carriers / stakeholder workgroup	*Summary results only, score relative to all carriers, prevalence for carrier. Separately show an exhibit with low/high simulated scenarios for the impact of uninsured population movement in 2015*	*Simulation Deliverables 5.6*	*State: HIX Chief Commun. Officer*	5/1/2014	5/31/2014
48	Exchange Risk Adjustment Run for 2014 (by April 2015)			*State: HIX Executive Director and Team*	4/1/2015	4/1/2015

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 2: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State knows ahead of time they will be using the federal model and parameters, Late start (July 2012)						
1	Market survey	*Identify market share and collected premium for all individual/small/large group carriers in state as well as self-funded plan TPAs; collect contact information*	*Analysis & Simulations, Section 5.1*	*State: Request from the Division of Insurance*	7/15/2012	8/15/2012
2	Establish Risk Adjustment and Reinsurance Stakeholder Workgroups	*States may choose to set up a task force for the purpose of coordinating initial activity for risk adjustment and reinsurance, although management of reinsurance and risk adjustment will likely fall to other current state entities or the state exchange. This entity will tap into personnel knowledgeable in specific fields (e.g. information technology, data privacy, liaison with legislative/regulatory authorities).*	*Stakeholder Engagement, Section 3.1*	*State: HIX Executive Director*	7/15/2012	8/15/2012
3	Develop estimates for administration costs and an administrative financing model to support risk adjustment and reinsurance	*If risk adjustment not financed through assessment, develop alternative financing to support preliminary studies and eventual risk adjustment administration (reinsurance can be supported through their assessments on premiums and claims)*	*Program Financing, Section 6.2*	*State: RARE Workgroup*	7/15/2012	8/31/2012
4	Regulatory changes to data submission requirements	*Note that these are changes to existing regulation around data collection in light of work on, primarily, risk adjustment data needs*	*Legislative Timeframes, Section 7.1*	*State: RARE Workgroup, HIX Executive Director*	7/15/2012	9/30/2012
5	Assess reinsurance capabilities and eligible reinsurers in State	*ACA requires a not-for-profit reinsurer to administer the program. Administrative functions may still be outsourced and should be reviewed as part of vendor contracting assessment.* *1. Premium collection and Treasury submissions* *2. Claims adjudication and reimbursement* *3. Ability to respond within defined timeframes*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: RARE Workgroup with IT expert from High Risk Pool or possibly outside contractor to issue report on cost/feasibility under several options (state maintains / vendor contracting etc.); HIX Director of Human Resources*	8/15/2012	10/15/2012
6	Meet with carriers, workgroup, and stakeholders to provide basic education of risk adjustment and reinsurance program and to discuss purpose and upcoming process	*1. Prospective / Concurrent* *2. Data elements used by the model* *3. Mechanics and timing of risk adjustment* *4. Develop rating variables / cohorts (e.g. are children under 1 a separate category?)* *5. Integration with geographic rating variable* *6. Integration with risk corridor calculation / timing*	*Stakeholder Engagement, Section 3*	*State: RARE task force + expert consultant + BOD + Stakeholder Workgroup*	9/1/2012	9/30/2012
7	Develop data request for risk adjustment and reinsurance	*1. Develop data dictionary of elements to be collected* *2. Provisions for privacy and cross-plan/time member identification* *3. Data formatting*	*Analysis & Simulations, Section 5*	*State: RARE Workgroup / outside contractor, HIX General Counsel*	9/15/2012	10/15/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 2: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State knows ahead of time they will be using the federal model and parameters, Late start (July 2012)						
8	Develop data collection schedule and data auditing procedures	*1. Threshold procedures for data quality,* *2. Mechanism to accept/reject records,* *3. Data re-submission timeline* *4. Data extension period (60 assumed in this workplan),*	*Analysis & Simulations, Section 5; Data Review and Audit, Section 6.7*	*State: RARE Workgroup / outside contractor*	9/15/2012	10/15/2012
9	Release of federal Risk Adjustment Model and "advance" Reinsurance Parameters	*The timeline assumes that the required date to file alternative risk adjustment methodology will be 1 month from the release of the federal model*	*Simulation Timing, Section 5.5*	*HHS*	10/15/2012	10/15/2012
10	Distribute data request to carriers / stakeholder workgroup for both risk adjustment and reinsurance. Communicate data collection schedule and auditing procedures to carriers.		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	10/15/2012	10/31/2012
11	Data collection for risk adjustment	*Experience with dates of service through 7/31/2012, paid through 10/31/2012.*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	11/1/2012	11/30/2012
12	Data collection for reinsurance	*Experience with dates of service through 7/31/2012, paid through 10/31/2012.*	*Analysis & Simulations, Section 5*	*State: HIX CFO, HIX manager of finance and analytics, expert consultant*	11/1/2012	11/30/2012
13	Analyze the potential impact of uninsureds	*This can be done through a simulation approach, generating scenarios of low/high impact to results from round 1. The assumptions underlying such an analysis need to be transparently communicated to carriers.*	*Analysis & Simulations, Sections 5.3 - 5.4*	*State: HIX CFO, HIX manager of finance and analytics, expert consultant*	11/30/2012	12/31/2012
14	File request for exception from minimum standards for data collection. Operational APCD on or before January 1, 2013 is exempt from minimum data collection standards for risk adjustment		*Filing with HHS, Section 5.7*	*State: HIX Chief Commun. Officer*	12/1/2012	12/31/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 2: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State knows ahead of time they will be using the federal model and parameters, Late start (July 2012)						
15	Produce Round 1 of reinsurance simulations based on agreed upon parameters	*1. State/contractor reviews expected premiums (FI) and claims paid (SF)* *2. Data reconciliation checks (financials)* *3. State/contractor reviews expected claim reimbursements* *4. Includes review of uninsured entering market*	*Key Decisions, Section 2.2; Reinsurance Simulations, Section 5.4*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	12/1/2012	1/31/2013
16	Produce Round 1 of risk adjustment results based on agreed upon methodology to determine impact on each carrier	*1. State/contractor runs risk adjustment model on data* *2. Data reconciliation checks (financials)* *3. Data quality diagnostics, especially those relating to risk adjustment* *4. Prevalence reports*	*Key Decisions, Section 2.2; Risk Adjustment Simulations, Section 5.3*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	12/1/2012	1/31/2013
17	Meet with carriers interested in understanding their own results more and addressing data concerns		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: Stakeholder Workgroup*	1/31/2013	2/28/2013
18	Present results to HIX leadership	*May not be necessary*	*Simulation Deliverables 5.6*	*State: HIX CFO, other senior staff*	1/31/2013	3/15/2013
19	If needed based on problems seen in results, receive revised data from carriers	*If there is a problem with any carrier's data, and if it can be resolved within this time frame, then receive updated data from all carriers.*	*Analysis & Simulations, Section 5*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	3/1/2013	3/31/2013
20	Produce revised results for risk adjustment and reinsurance	*This is the information that will be expected to be used within the calculation of rates for 2014 (and filed in particular states). Should allow at least 2 months for carriers' actuaries to incorporate this information into rates.*	*Key Decisions, Section 2.2; Simulations, Sections 5.3 - 5.4*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	4/1/2013	4/30/2013
21	Establishment of process, procedures, and schedules for collection of reinsurance assessment on premium (FI) and paid claims (SF)	*1) Collect assessments to support claims and administrative costs* *2) Submit Treasury's portion of assessments* *3) Timing to be established after federal input*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: HIX CFO, outside contractor, although still waiting for federal guidance on these items*	4/1/2013	6/30/2013
22	Establishment of process, procedures, and schedules for reimbursement of reinsurance claims	*1) Reporting requirements for reimbursement* *2) Methods to receive/manage/store data submission* *3) Timing of expected reimbursements* *4) Method of reducing payment in case of reimbursements exceeding payments*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: HIX CFO, outside contractor, although still waiting for federal guidance on these items*	4/1/2013	6/30/2013

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 2: Detailed data is submitted (APCD or other) and centralized processing is used to evaluate, State knows ahead of time they will be using the federal model and parameters, Late start (July 2012)						
23	Develop accounting procedures, funds flow diagrams, and cash management infrastructure for reinsurance program		*Accounting Funds Flow & Cash Management, Section 6.5*	*State: HIX CFO, reinsurance entity / outside contractor*	4/1/2013	6/30/2013
24	Other key date: carriers to submit rate filings for 2014 premiums (approximate)		*Simulation Timing, Section 5.5*	*Carriers*	6/1/2013	6/30/2013
25	Develop reporting protocols and schedule back to State, carriers, and TPAs; including processes and procedures for auditing		*Reporting & Transparency Plan, Section 6.6*	*State: HIX CFO, reinsurance entity / outside contractor*	7/1/2013	9/30/2013
26	Testing of processes and procedures established for collection of assessment and claims reimbursements		*Accounting Funds Flow & Cash Management, Section 6.5*	*State: HIX CFO, reinsurance entity / outside contractor*	7/1/2013	9/30/2013
27	Second round of data submission (30-day window)	*CY2013, paid through 4-1-14. This round is used to provide carriers information for 2015 pricing*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	4/1/2014	4/30/2014
28	Prepare and share results from round 2 with carriers / stakeholder workgroup	*Summary results only, score relative to all carriers, prevalence for carrier. Separately show an exhibit with low/high simulated scenarios for the impact of uninsured population movement in 2015*	*Simulation Deliverables 5.6*	*State: HIX Chief Commun. Officer*	5/1/2014	5/31/2014
29	Exchange Risk Adjustment Run for 2014 (by April 2015)			*State: HIX Executive Director and Team*	4/1/2015	4/1/2015

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 3: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State knows ahead of time they will be using the federal model and para						
1	Market survey	*Identify market share and collected premium for all individual/small/large group carriers in state as well as self-funded plan TPAs; collect contact information*	*Analysis & Simulations, Section 5.1*	*State: Request from the Division of Insurance*	7/15/2012	8/15/2012
2	Establish Risk Adjustment and Reinsurance Stakeholder Workgroups	*States may choose to set up a task force for the purpose of coordinating initial activity for risk adjustment and reinsurance, although management of reinsurance and risk adjustment will likely fall to other current state entities or the state exchange. This entity will tap into personnel knowledgeable in specific fields (e.g. information technology, data privacy, liaison with legislative/regulatory authorities).*	*Stakeholder Engagement, Section 3.1*	*State: HIX Executive Director*	7/15/2012	8/15/2012
3	Develop estimates for administration costs and an administrative financing model to support risk adjustment and reinsurance	*If risk adjustment not financed through assessment, develop alternative financing to support preliminary studies and eventual risk adjustment administration (reinsurance can be supported through their assessments on premiums and claims)*	*Program Financing, Section 6.2*	*State: RARE Workgroup*	7/15/2012	8/31/2012
4	Regulatory changes to data submission requirements	*Note that these are changes to existing regulation around data collection in light of work on, primarily, risk adjustment data needs*	*Legislative Timeframes, Section 7.1*	*State: RARE Workgroup, HIX Executive Director*	7/15/2012	9/30/2012
5	Assess reinsurance capabilities and eligible reinsurers in State	*ACA requires a not-for-profit reinsurer to administer the program. Administrative functions may still be outsourced and should be reviewed as part of vendor contracting assessment.* *1. Premium collection and Treasury submissions* *2. Claims adjudication and reimbursement* *3. Ability to respond within defined timeframes*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: RARE Workgroup with IT expert from High Risk Pool or possibly outside contractor to issue report on cost/feasibility under several options (state maintains / vendor contracting etc.); HIX Director of Human Resources*	8/1/2012	9/30/2012
6	Meet with carriers, workgroup, and stakeholders to provide basic education of risk adjustment and reinsurance program and to discuss purpose and upcoming process	*1. Prospective / Concurrent* *2. Data elements used by the model* *3. Mechanics and timing of risk adjustment* *4. Develop rating variables / cohorts (e.g. are children under 1 a separate category?)* *5. Integration with geographic rating variable* *6. Integration with risk corridor calculation / timing*	*Stakeholder Engagement, Section 3*	*State: RARE task force + expert consultant + BOD + Stakeholder Workgroup*	8/1/2012	8/15/2012
7	Develop data request for risk adjustment and reinsurance	*1. Develop data dictionary of elements to be collected* *2. Provisions for privacy and cross-plan/time member identification* *3. Data formatting*	*Analysis & Simulations, Section 5*	*State: RARE Workgroup / outside contractor, HIX General Counsel*	8/15/2012	9/15/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 3: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State knows ahead of time they will be using the federal model and para						
8	Develop data collection schedule and data auditing procedures	*1. Threshold procedures for data quality,* *2. Mechanism to accept/reject records,* *3. Data re-submission timeline* *4. Data extension period (60 assumed in this workplan),*	*Analysis & Simulations, Section 5; Data Review and Audit, Section 6.7*	*State: RARE Workgroup / outside contractor*	8/15/2012	9/15/2012
9	Meet with carrier personnel who will be running risk adjustment model and providing data response for risk adjustment and reinsurance. The preliminary data requests will be discussed.	*1. Explain approach of running risk adjustment tool, assuming federal model will be a somewhat typical structure* *2. Explain data request for risk adjustment and reinsurance* *3. Clarify questions regarding the data request and timing*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	9/15/2012	10/15/2012
10	Release of federal Risk Adjustment Model and "advance" Reinsurance Parameters	*The timeline assumes that the required date to file alternative risk adjustment methodology will be 1 month from the release of the federal model*	*Simulation Timing, Section 5.5*	*HHS*	10/15/2012	10/15/2012
11	Distribute finalized data request to carriers / stakeholder workgroup for both risk adjustment and reinsurance. Communicate data collection schedule and auditing procedures to carriers.		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	10/15/2012	10/31/2012
12	Data collection for risk adjustment	*Experience with dates of service through 7/31/2012, paid through 10/31/2012. This is the time needed for carriers to run risk adjustment model.*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	11/1/2012	12/31/2012
13	Data collection for reinsurance	*Experience with dates of service through 7/31/2012, paid through 10/31/2012. This is the time needed for carriers to categorize claims according to the reinsurance parameters outlined.*	*Analysis & Simulations, Section 5*	*State: HIX CFO, HIX manager of finance and analytics, expert consultant*	11/1/2012	12/31/2012
14	Analyze the potential impact of uninsureds	*This can be done through a simulation approach, generating scenarios of low/high impact to results from round 1. The assumptions underlying such an analysis need to be transparently communicated to carriers.*	*Analysis & Simulations, Sections 5.3 - 5.4*	*State: HIX CFO, HIX manager of finance and analytics, expert consultant*	11/1/2012	12/31/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 3: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State knows ahead of time they will be using the federal model and para						
15	File request for exception from minimum standards for data collection. Operational APCD on or before January 1, 2013 is exempt from minimum data collection standards for risk adjustment		*Filing with HHS, Section 5.7*	*State: HIX Chief Commun. Officer*	12/1/2012	12/31/2012
16	Produce Round 1 of reinsurance outcomes based on federal parameters	*1. Carriers run data through models and send specified information to HIX* *2. HIX/contractor reviews expected premiums (FI) or claims paid (SF) as well as reimbursements* *3. HIX/contractor completes review of aggregate market and carrier results for consistency* *4. Includes review of uninsured entering market*	*Key Decisions, Section 2.2; Reinsurance Simulations, Section 5.4*	*Carriers* *State: HIX CFO, HIX manager of finance and analytics, contractor*	1/1/2013	1/31/2013
17	Produce Round 1 of risk adjustment results based on federal model to determine impact on each carrier	*1. Carriers run risk adjustment model with their data and submit to HIX/contractor* *2. HIX/Carriers review results by carrier and in aggregate for consistency and reasonableness* *3. Data quality diagnostics, especially those relating to risk adjustment* *4. Prevalence reports*	*Key Decisions, Section 2.2; Risk Adjustment Simulations, Section 5.3*	*Carriers* *State: HIX CFO, HIX manager of finance and analytics, contractor*	1/1/2013	1/31/2013
18	Meet with carriers interested in understanding their own results more and addressing data concerns		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: Stakeholder Workgroup*	1/31/2013	2/28/2013
19	Present results to HIX leadership	*May not be necessary*	*Simulation Deliverables 5.6*	*State: HIX CFO, other senior staff*	1/31/2013	3/15/2013
20	If needed based on problems seen in results, receive revised data from carriers	*If there is a problem with any carrier's data, and if it can be resolved within this time frame, then receive updated data from all carriers.*	*Analysis & Simulations, Section 5*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	3/1/2013	4/1/2013
21	Produce revised results for risk adjustment and reinsurance	*This is the information that will be expected to be used within the calculation of rates for 2014 (and filed in particular states). Should allow 2 months for carriers' actuaries to incorporate this information into rates.*	*Key Decisions, Section 2.2; Simulations, Sections 5.3 - 5.4*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	4/1/2013	4/30/2013
22	Establishment of process, procedures, and schedules for collection of reinsurance assessment on premium (FI) and paid claims (SF)	*1) Collect assessments to support claims and administrative costs* *2) Submit Treasury's portion of assessments* *3) Timing to be established after federal input*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: HIX CFO, outside contractor, although still waiting for federal guidance on these items*	4/1/2013	6/30/2013

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 3: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State knows ahead of time they will be using the federal model and para						
23	Establishment of process, procedures, and schedules for reimbursement of reinsurance claims	*1) Reporting requirements for reimbursement* *2) Methods to receive/manage/store data submission* *3) Timing of expected reimbursements* *4) Method of reducing payment in case of reimbursements exceeding payments*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: HIX CFO, outside contractor, although still waiting for federal guidance on these items*	4/1/2013	6/30/2013
24	Develop accounting procedures, funds flow diagrams, and cash management infrastructure for reinsurance program		*Accounting Funds Flow & Cash Management, Section 6.5*	*State: HIX CFO, reinsurance entity / outside contractor*	4/1/2013	6/30/2013
25	Other key date: carriers to submit rate filings for 2014 premiums (approximate)		*Simulation Timing, Section 5.5*	*Carriers*	6/1/2013	6/30/2013
26	Develop reporting protocols and schedule back to State, carriers, and TPAs; including processes and procedures for auditing		*Reporting & Transparency Plan, Section 6.6*	*State: HIX CFO, reinsurance entity / outside contractor*	7/1/2013	9/30/2013
27	Testing of processes and procedures established for collection of assessment and claims reimbursements		*Accounting Funds Flow & Cash Management, Section 6.5*	*State: HIX CFO, reinsurance entity / outside contractor*	7/1/2013	9/30/2013
28	Second round of data submission (30-day window)	*CY2013, paid through 4-1-14. This round is used to provide carriers information for 2015 pricing*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	4/1/2014	4/30/2014
29	Prepare and share results from round 2 with carriers / stakeholder workgroup	*Summary results only, score relative to all carriers, prevalence for carrier. Separately show an exhibit with low/high simulated scenarios for the impact of uninsured population movement in 2015*	*Simulation Deliverables 5.6*	*State: HIX Chief Commun. Officer*	5/1/2014	5/31/2014
30	Exchange Risk Adjustment Run for 2014 (by April 2015)			*State: HIX Executive Director and Team*	4/1/2015	4/1/2015

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 4: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State is considering alternative methodology and parameters, relatively						
1	Market survey	*Identify market share and collected premium for all individual/small/large group carriers in state as well as self-funded plan TPAs; collect contact information*	*Analysis & Simulations, Section 5.1*	*State: Request from the Division of Insurance*	10/15/2011	11/15/2011
2	Establish Risk Adjustment and Reinsurance (RARE) Workgroup	*States may choose to set up a task force for the purpose of coordinating initial activity for risk adjustment and reinsurance, although management of reinsurance and risk adjustment will likely fall to other current state entities or the state exchange. This entity will tap into personnel knowledgeable in specific fields (e.g. information technology, data privacy, liaison with legislative/regulatory authorities).*	*Program Governance, Section 6.1; Stakeholder Engagement Plan, Section 3*	*State: Key state agencies establish RARE Workgroup*	10/15/2011	11/30/2011
3	Develop estimates for administration costs and an administrative financing model to support risk adjustment and reinsurance	*If risk adjustment not financed through assessment, develop alternative financing to support preliminary studies and eventual risk adjustment administration (reinsurance can be supported through their assessments on premiums and claims)*	*Program Financing, Section 6.2*	*State: RARE Workgroup*	10/15/2011	11/30/2011
4	Assess data handling capabilities	*1. Equipment / Staffing* *2. Vendor contracting* *3. Software licensing* *4. Hardware requirements (data storage)*	*Risk Adjustment Administrative Infrastructure, Section 6.3*	*State: RARE Workgroup with IT expert from Medicaid Office or possibly outside contractor to issue report on cost/feasibility under several options (state maintains / vendor contracting etc.); HIX Director of Human Resources*	10/15/2011	11/30/2011
5	Assess reinsurance capabilities and eligible reinsurers in State	*ACA requires a not-for-profit reinsurer to administer the program. Administrative functions may still be outsourced and should be reviewed as part of vendor contracting assessment.* *1. Premium collection and Treasury submissions* *2. Claims adjudication and reimbursement* *3. Ability to respond within defined timeframes*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: RARE Workgroup with IT expert from High Risk Pool or possibly outside contractor to issue report on cost/feasibility under several options (state maintains / vendor contracting etc.); HIX Director of Human Resources*	10/15/2011	11/30/2011
6	Develop data request for risk adjustment and reinsurance	*1. Develop data dictionary of elements to be collected* *2. Provisions for privacy and cross-plan/time member identification* *3. Data formatting*	*Analysis & Simulations, Section 5*	*State: RARE Workgroup / outside contractor, HIX General Counsel*	10/15/2011	11/15/2011
7	Develop data collection schedule and data auditing procedures	*1. Threshold procedures for data quality,* *2. Mechanism to accept/reject records,* *3. Data re-submission timeline* *4. Data extension period (60 assumed in this workplan),*	*Analysis & Simulations, Section 5; Data Review and Audit, Section 6.7*	*State: RARE Workgroup / outside contractor*	10/15/2011	11/15/2011

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 4: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State is considering alternative methodology and parameters, relatively						
8	Establish Risk Adjustment and Reinsurance Stakeholder Workgroups	*Some states may wish to create a workgroup of stakeholders for risk adjustment, reinsurance, or both in order to help structure input and feedback into the development of the risk mitigation programs. Having such a forum may help consolidate and streamline the process for providing input, as well as to provide a forum for discussion amongst stakeholders about their shared and individual concerns and/or goals for the risk mitigation program. This is more relevant for risk adjustment versus reinsurance due to the higher level of complexity.*	*Stakeholder Engagement, Section 3.1*	*State: HIX Executive Director*	10/15/2011	11/15/2011
9	Communicate draft data collection schedule to carriers, invite comment	*Good to solicit feedback on feasibility of submission schedule, however may not be able to change it much. Good to know ahead of time if a large carrier(s) will be unable to submit information, and to figure out ways to address it*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	11/15/2011	12/15/2011
10	Revise data collection schedule, auditing procedures based on critical feedback		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: RARE Workgroup, Stakeholder Workgroup*	12/15/2011	12/31/2011
11	Communicate data collection schedule and auditing procedures to carriers	*Send data request out, but simultaneously draft pending legislative/regulatory changes. This should give carriers more time to put data together.*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	1/1/2012	1/31/2012
12	Investigate alternative risk adjustment methodology and state-specific reinsurance parameters	*Federal model will not be available for either program. States will need to decide their risk adjustment methodology based on alternative model / white paper and HHS model's white paper and stakeholder feedback / expert assessment. For reinsurance, states will need to model various alternatives without the benefit of knowing HHS' assessment rate.*	*Key Decisions, Sections 2.2 - 2.3; Analysis & Simulations, Sections 5.3 - 5.4*	*State: Stakeholder Workgroup*	10/15/2011	11/30/2011
13	Develop preliminary proposal of a possible risk adjustment methodology (and timeline) to be shared with carriers	*1. Prospective / Concurrent* *2. Data elements used by the model* *3. Mechanics and timing of risk adjustment* *4. Develop rating variables / cohorts (e.g. are children under 1 a separate category?)* *5. Integration with geographic rating variable* *6. Integration with risk corridor calculation / timing*	*Key Decisions, Section 2.2; Simulation Deliverables, Section 5.3 and 5.6*	*State: RARE Workgroup + expert consultant + HIX Executive Director + Stakeholder Workgroup*	11/15/2011	1/15/2012
14	Develop preliminary proposal of possible reinsurance parameters (and timeline) to be shared with carriers	*1. Coinsurance rate* *2. Attachment point* *3. Reinsurance cap* *4. Timing of assessments and claims payments* *5. Alternatives to deal with deficit/surplus*	*Key Decisions, Section 2.3; Simulation Deliverables, Sections 5.4 and 5.6*	*State: RARE Workgroup + expert consultant + HIX Executive Director + Stakeholder Workgroup*	11/15/2011	1/15/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 4: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State is considering alternative methodology and parameters, relatively						
15	Solicit comments from carriers on alternative risk adjustment methodology and potential state-specific reinsurance parameters		*Stakeholder Engagement, Section 3.3; Simulation Deliverables 5.6*	*State: HIX Chief Commun. Officer*	12/1/2011	12/31/2011
16	Regulatory changes to data submission requirements	*Note that these are changes to existing regulation around data collection in light of work on, primarily, risk adjustment data needs*	*Legislative Timeframes, Section 7.1*	*State: RARE Workgroup, HIX Executive Director*	1/1/2012	3/31/2012
17	Distribute preliminary proposal of risk adjustment methodology and reinsurance parameters (and timelines) to carriers		*Stakeholder Engagement, Section 3.3; Scenario Definition, Section 4;*	*State: HIX Chief Commun. Officer*	1/15/2012	1/15/2012
18	Meet with stakeholder workgroup(s) to discuss purpose and upcoming process		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: RARE Workgroup, HIX Executive Director*	1/15/2012	1/31/2012
19	Communicate the program specifics with RARE Workgroup after meeting with carriers		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Executive Director, HIX CFO, other senior staff, BOD*	2/1/2012	2/29/2012
20	Meet with carrier personnel who will be running risk adjustment model and providing data response for risk adjustment and reinsurance. The preliminary data requests will be discussed.	*1. Explain approach of running risk adjustment tool, assuming federal model will be a somewhat typical structure* *2. Explain data request for risk adjustment and reinsurance* *3. Clarify questions regarding the data request and timing*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	2/1/2012	2/29/2012
21	Distribute finalized data request to carriers / stakeholder workgroup for both risk adjustment and reinsurance. Communicate data collection schedule and auditing procedures to carriers.	*This will be the second distribution of the data request and collection timeline, this time with finalized regulation mandating compliance.*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	3/1/2012	3/15/2012
22	First round of data collection for risk adjustment (up to 60 day extension on deadline)	*CY2011 experience, paid through 4/1/12. This is the time needed for carriers to run the risk adjustment model as outlined.*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	3/15/2012	5/15/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 4: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State is considering alternative methodology and parameters, relatively						
23	First round of data collection for reinsurance	*CY2011 premiums and claims, paid through 4/1/12. This is the time needed for carriers to categorize claims according to the reinsurance parameters outlined.*	*Analysis & Simulations, Section 5*	*State: HIX CFO, HIX manager of finance and analytics, expert consultant*	3/15/2012	5/15/2012
24	Analyze the potential impact of uninsureds	*This can be done through a simulation approach, generating scenarios of low/high impact to results from round 1. The assumptions underlying such an analysis need to be transparently communicated to carriers.*	*Analysis & Simulations, Sections 5.3 - 5.4*	*State: HIX CFO, HIX manager of finance and analytics, expert consultant*	3/15/2012	5/15/2012
25	Produce Round 1 of reinsurance simulations based on agreed upon parameters	*1. Carriers run data through models and send specified information to HIX* *2. HIX/contractor reviews expected premiums (FI) or claims paid (SF) as well as reimbursements* *3. HIX/contractor completes review of aggregate market and carrier results for consistency* *4. Includes review of uninsured entering market*	*Key Decisions, Section 2.2; Reinsurance Simulations, Section 5.4*	*Carriers* *State: HIX CFO, HIX manager of finance and analytics, contractor*	5/15/2012	7/31/2012
26	Produce Round 1 of risk adjustment results based on agreed upon methodology to determine impact on each carrier	*1. Carriers run risk adjustment model with their data and submit to HIX/contractor* *2. HIX/Carriers review results by carrier and in aggregate for consistency and reasonableness* *3. Data quality diagnostics, especially those relating to risk adjustment* *4. Prevalence reports*	*Key Decisions, Section 2.2; Risk Adjustment Simulations, Section 5.3*	*Carriers* *State: HIX CFO, HIX manager of finance and analytics, contractor*	5/15/2012	7/31/2012
27	Provide aggregate results from Round 1 to back to carriers	*Summary results only, score relative to all carriers, prevalence for carrier. Separately show an exhibit with low/high simulated scenarios for the impact of uninsured population movement in 2014*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	8/1/2012	8/31/2012
28	Meet with carriers interested in understanding their own results more and addressing data concerns		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: Stakeholder Workgroup*	9/15/2012	10/15/2012
29	Make recommendation on whether to use federal or alternative risk adjustment methodology. Present results from Round 1 to RARE Workgroup and make final decision.		*Simulation Deliverables 5.6*	*State: HIX Executive Director, HIX CFO, other senior staff*	10/1/2012	10/31/2012
30	Release of federal Risk Adjustment Model and "advance" Reinsurance Parameters	*The timeline assumes that the required date to file alternative risk adjustment methodology will be 1 month from the release of the federal model*	*Simulation Timing, Section 5.5*	*HHS*	10/15/2012	10/15/2012
31	Analysis of the federal reinsurance parameters. Present results to RARE Workgroup and make final decision.	*Run federal model on collected data, compare performance, included data, other aspects to the alternative model. Compare financial impact on each carrier under HHS and alternative model.*	*Simulation Deliverables 5.6*	*State: HIX CFO, HIX manager of finance and analytics, contractor*	10/15/2012	11/15/2012

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 4: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State is considering alternative methodology and parameters, relatively						
32	Carriers run updated data on federal risk adjustment model. Provide State subcontractor results based on data request.	*The timing here is very short.*	*Simulation Deliverables 5.6*	*State: HIX Executive Director, HIX CFO, other senior staff*	10/15/2012	10/31/2012
33	Compile risk adjustment results from federal model and share results with stakeholder workgroups. Present results to RARE Workgroup and make final decision.	*The timing here is very short. These results can be shared through a meeting / web-ex approach and input is collected. The exchange takes the decision to either pursue an alternative methodology, or adopt HHS model*	*Simulation Deliverables 5.6*	*State: HIX Executive Director, HIX CFO, other senior staff*	11/1/2012	11/15/2012
34	If decide to not use federal model, file alternative risk adjustment methodology and/or alternative reinsurance parameters with HHS		*Filing with HHS, Section 5.7*	*State: HIX Chief Commun. Officer*	11/1/2012	11/1/2012
35	File request for exception from minimum standards for data collection. Operational APCD on or before January 1, 2013 is exempt from minimum data collection standards for risk adjustment		*Filing with HHS, Section 5.7*	*State: HIX Chief Commun. Officer*	12/15/2012	12/31/2012
36	HHS to inform State if alternative method for risk adjustment and/or reinsurance has been accepted		*Simulation Timing, Section 5.5*	*HHS*	1/1/2013	1/15/2013
37	Second round of data collection	*Experience with dates of service through 9/30/2012, paid through 12/31/2012. This round is used to provide carriers information for 2014 pricing. Carriers run the risk adjustment model chosen and supply updated reinsurance information.*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	1/1/2013	2/15/2013
38	Prepare and share results from round 2 with carriers / stakeholder workgroup	*Summary results only, score relative to all carriers, prevalence for carrier. Separately show an exhibit with low/high simulated scenarios for the impact of uninsured population movement in 2014*	*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	2/15/2013	3/15/2013
39	Respond to carrier questions related to Round 2		*Stakeholder Engagement, Sections 3.2 - 3.5*	*State: HIX Chief Commun. Officer*	3/15/2013	3/31/2013
40	State to provide notice of intent to local stakeholders that they will use alternative models, if applicable.		*Simulation Timing, Section 5.5*	*State: HIX Chief Commun. Officer*	3/15/2013	3/31/2013
41	Present results from Round 2 to RARE Workgroup		*Simulation Deliverables 5.6*	*State: HIX Executive Director, HIX CFO, other senior staff, RARE BOD*	4/1/2013	4/30/2013

Appendix B - Detailed Risk Adjustment and Reinsurance Timeline

Ref	Detail Tasks	Decisions/Considerations	Narrative Reference Section	Responsibility	Start Date	Completion Date
Scenario 4: Summarized data is submitted (carriers run the risk adjustment and reinsurance tools and send results back to State or State subcontractor to compile), State is considering alternative methodology and parameters, relatively						
42	Establishment of process, procedures, and schedules for collection of reinsurance assessment on premium (FI) and paid claims (SF)	*1) Collect assessments to support claims and administrative costs* *2) Submit Treasury's portion of assessments* *3) Timing to be established after federal input*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: HIX CFO, outside contractor, although still waiting for federal guidance on these items*	4/1/2013	6/30/2013
43	Establishment of process, procedures, and schedules for reimbursement of reinsurance claims	*1) Reporting requirements for reimbursement* *2) Methods to receive/manage/store data submission* *3) Timing of expected reimbursements* *4) Method of reducing payment in case of reimbursements exceeding payments*	*Reinsurance Administrative Infrastructure, Section 6.4*	*State: HIX CFO, outside contractor, although still waiting for federal guidance on these items*	4/1/2013	6/30/2013
44	Develop accounting procedures, funds flow diagrams, and cash management infrastructure for reinsurance program		*Accounting Funds Flow & Cash Management, Section 6.5*	*State: HIX CFO, reinsurance entity / outside contractor*	4/1/2013	6/30/2013
45	Other key date: carriers to submit rate filings for 2014 premiums (approximate)		*Simulation Timing, Section 5.5*	*Carriers*	6/1/2013	6/30/2013
46	Develop reporting protocols and schedule back to State, carriers, and TPAs; including processes and procedures for auditing		*Reporting & Transparency Plan, Section 6.6*	*State: HIX CFO, reinsurance entity / outside contractor*	7/1/2013	9/30/2013
47	Testing of processes and procedures established for collection of assessment and claims reimbursements		*Accounting Funds Flow & Cash Management, Section 6.5*	*State: HIX CFO, reinsurance entity / outside contractor*	7/1/2013	9/30/2013
48	Third round of data submission (30-day window)	*CY2013, paid through 4-1-14. This round is used to provide carriers information for 2015 pricing*	*Analysis & Simulations, Section 5*	*State: HIX Director of IT Services, HIX Chief Commun. Officer, HIX Executive Director*	4/1/2014	4/30/2014
49	Prepare and share results from round 3 with carriers / stakeholder workgroup	*Summary results only, score relative to all carriers, prevalence for carrier. Separately show an exhibit with low/high simulated scenarios for the impact of uninsured population movement in 2015*	*Simulation Deliverables 5.6*	*State: HIX Chief Commun. Officer*	5/1/2014	5/31/2014
50	Exchange Risk Adjustment Run for 2014 (by April 2015)			*State: HIX Executive Director and Team*	4/1/2015	4/1/2015

Appendix C - Risk Adjustment Implementation in 2014 and 2015, Section 8.2

High Level Activity	Iteration	Detail Tasks	Decisions/Considerations	Start Date	Completion Date
Option A: Incorporate interim process during 2014. Interim process is based on medical diagnosis model.					
1	Interim #1, 2014	Collect Data	*This includes medical (and perhaps Rx) claims data, enrollment data, and premium information. Dates of service 1/1/14-6/30/14, paid through 9/30/14*	10/1/2014	10/15/2014
2	Interim #1, 2014	Perform Calculations		10/15/2014	11/30/2014
3	Interim #1, 2014	Distribute Results		12/1/2014	12/15/2014
4	Interim #1, 2014	State Collects Charges	*Regulations from HHS are pending on this requirement*	12/15/2014	1/15/2015
5	Interim #1, 2014	State Distributes Payments		1/15/2015	1/31/2015
6	Interim #2 2014	Collect Enrollment Data	*Enrollment for 1/2014 thru 11/2014*	12/1/2014	12/15/2014
7	Interim #2 2014	Calculate and Distribute Results	*This involves applying member risk scores to Jul-Nov enrollment, plus any reconciliation for changes in enrollment for the first half of the year*	12/15/2014	12/31/2014
8	Interim #2 2014	State Collects Charges	*Regulations from HHS are pending on this requirement*	1/1/2015	1/31/2015
9	Interim #2 2014	State Distributes Payments		2/1/2015	2/15/2015
10	Interim #3 2014	Collect Enrollment Data	*Enrollment for 1/2014 thru 12/2014*	1/1/2015	1/15/2015
11	Interim #3 2014	Calculate and Distribute	*This involves applying member risk scores to Dec enrollment, plus any reconciliation for changes in YTD*	1/15/2015	1/31/2015
12	Interim #3 2014	State Collects Charges	*Regulations from HHS are pending on this requirement*	2/1/2015	2/28/2015
13	Interim #3 2014	State Distributes Payments		3/1/2015	3/15/2015
14	Interim #1 2015	Collect Enrollment Data	*Enrollment for 1/2014 thru 1/2015*	2/1/2015	2/15/2015
15	Interim #1 2015	Calculate and Distribute Results	*This involves applying member risk scores to Jan enrollment, plus any reconciliation for changes in YTD enrollment*	2/15/2015	2/28/2015
16	Interim #1 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	3/1/2015	3/31/2015
17	Interim #1 2015	State Distributes Payments		4/1/2015	4/15/2015
18	Interim #2 2015	Collect Enrollment Data	*Enrollment for 1/2014 thru 2/2015*	3/1/2015	3/15/2015
19	Interim #2 2015	Calculate and Distribute	*This involves applying member risk scores to Feb enrollment, plus any reconciliation for changes in YTD*	3/15/2015	3/31/2015
20	Interim #2 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	4/1/2015	4/30/2015
21	Interim #2 2015	State Distributes Payments		5/1/2015	5/15/2015
22	Final 2014, Interim 2015	Collect Data (including medical)	*This includes medical and perhaps Rx data, enrollment data, and premium information. 1/1/14-12/31/2014 dates of service, paid through 3/31/15. Enrollment for 1/2014 thru 3/2015.*	4/1/2015	4/15/2015
23	Interim #3 2015	Calculate and Distribute	*This involves applying member risk scores to Mar enrollment, plus any reconciliation for changes in YTD*	4/15/2015	4/30/2015
24	Interim #3 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	5/1/2015	5/31/2015
25	Interim #3 2015	State Distributes Payments		6/1/2015	6/15/2015
26	Final 2014	Perform Calculations	*This will involve revising 2014 risk scores for people based on new data. Calculations will incorporate a "correction" for prior interim payments and charges*	4/15/2015	6/15/2015
27	Final 2014	Distribute Results	*Results include reconciliation for 2014*	6/15/2015	6/30/2015
28	Final 2014	State Collects Charges	*Regulations from HHS are pending on this requirement*	7/1/2015	7/31/2015
29	Final 2014	State Distributes Payments		8/1/2015	8/15/2015
30	Interim #4 2015	Collect Enrollment Data	*Enrollment for 1/2015 thru 4/2015*	5/1/2015	5/15/2015
31	Interim #4 2015	Calculate and Distribute	*This involves applying member risk scores to Apr enrollment, plus any reconciliation for changes in YTD*	5/15/2015	5/31/2015
32	Interim #4 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	6/1/2015	6/30/2015
33	Interim #4 2015	State Distributes Payments		7/1/2015	7/15/2015
34	Interim #5 2015	Collect Enrollment Data	*Enrollment for 1/2015 thru 5/2015*	6/1/2015	6/15/2015
35	Interim #5 2015	Calculate and Distribute	*This involves applying member risk scores to May enrollment, plus any reconciliation for changes in YTD*	6/15/2015	6/30/2015
36	Interim #5 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	7/1/2015	7/31/2015
37	Interim #5 2015	State Distributes Payments		8/1/2015	8/15/2015
38	Interim #6 2015	Collect Enrollment Data	*Enrollment for 1/2015 thru 6/2015*	7/1/2015	7/15/2015
39	Interim #6 2015	Calculate and Distribute	*This involves applying member risk scores to June enrollment, plus any reconciliation for changes in YTD*	7/15/2015	7/31/2015
40	Interim #6 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	8/1/2015	8/31/2015

Appendix C - Risk Adjustment Implementation in 2014 and 2015, Section 8.2

High Level Activity	Iteration	Detail Tasks	Decisions/Considerations	Start Date	Completion Date
Option A: Incorporate interim process during 2014. Interim process is based on medical diagnosis model.					
41	Interim #6 2015	State Distributes Payments		9/1/2015	9/15/2015
42	Interim #7 2015	Collect Enrollment Data	*Enrollment for 1/2015 thru 7/2015*	8/1/2015	8/15/2015
43	Interim #7 2015	Calculate and Distribute	*This involves applying member risk scores to July enrollment, plus any reconciliation for changes in YTD*	8/15/2015	8/31/2015
44	Interim #7 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	9/1/2015	9/30/2015
45	Interim #7 2015	State Distributes Payments		10/1/2015	10/15/2015
46	Interim #8 2015	Collect Enrollment Data	*Enrollment for 1/2015 thru 8/2015*	9/1/2015	9/15/2015
47	Interim #8 2015	Calculate and Distribute Results	*This involves applying member risk scores to Aug enrollment, plus any reconciliation for changes in YTD enrollment*	9/15/2015	9/30/2015
48	Interim #8 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	10/1/2015	10/31/2015
49	Interim #8 2015	State Distributes Payments		11/1/2015	11/15/2015
50	Interim #9 2015	Collect Enrollment Data	*Enrollment for 1/2015 thru 9/2015*	10/1/2015	10/15/2015
51	Interim #9 2015	Calculate and Distribute Results	*This involves applying member risk scores to Sep enrollment, plus any reconciliation for changes in YTD enrollment*	10/15/2015	10/31/2015
52	Interim #9 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	11/1/2015	11/30/2015
53	Interim #9 2015	State Distributes Payments		12/1/2015	12/15/2015
54	Interim #10, 2015	Collect Data	*This includes medical (and perhaps Rx) claims data, enrollment data, and premium information. Dates of service 1/1/15-6/30/15, paid through 9/30/15*	10/1/2015	10/15/2015
55	Interim #10, 2015	Perform Calculations		10/15/2015	11/30/2015
56	Interim #10, 2015	Distribute Results		12/1/2015	12/15/2015
57	Interim #10, 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	12/15/2015	1/15/2016
58	Interim #10, 2015	State Distributes Payments		1/15/2016	1/31/2016
59	… continue monthly until Final 2015				
60	Final 2015	Collect Data	*This includes medical and perhaps Rx data, enrollment data, and premium information. 1/1/15-12/31/15 dates of service, paid through 3/31/16. Enrollment for Jan-15 thru Mar-16.*	4/1/2016	4/15/2016
61	Final 2015	Perform Calculations	*This will involve revising risk scores for people based on expanded data. Calculations will incorporate a "correction" for prior interim payments and charges*	4/15/2016	6/15/2016
62	Final 2015	Distribute Results		6/15/2016	6/30/2016
63	Final 2015	State Collects Charges	*Regulations from HHS are pending on this requirement*	7/1/2016	7/31/2016
64	Final 2015	State Distributes Payments		8/1/2016	8/15/2016